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ABSTRACT

This book presents a crisis management model that effectively bridges the areas of substance abuse and crisis intervention. A crisis alternatives model which can be incorporated into drug counseling programs is discussed, along with a four-step crisis intervention plan for use by crisis workers that includes: (1) establishing rapport; (2) gathering information; (3) devising a plan; (4) taking action based on the plan. The basic knowledge and skills counselors need to work with chemical abusers are identified and several treatment modes and available services are explored. Detailed descriptions are provided for the three behavior types (impulsive, withdrawn, social) that are most often seen in substance abuse crisis centers, with special attention given to each type's basic life issues and characteristic methods of handling stress. The role that chemicals play in helping each type to buttress and potentiate defenses is discussed, and specific recommendations about appropriate interventions are given. Special crisis situations involving hallucinations and polydrug use, as well as a section on treatment and referrals, are described using the three behavior types. The last chapter deals with interpretation and use of the model using a one-act play found in Appendix A. Additional appendices contain a crisis inventory, types of interaction effects, and a hallucination list. (NRB)

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# THE BOOK OF CHEMICAL CRISIS

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BY
FLOYD P. SOURS

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The inventory in Appendix B is primarily an adaptation of Arnold A. Lazarus, **Multimodal Behavior Therapy**, New York: Springer, 1976. Permission to reprint the Adaptation has been obtained in writing from Dr. Lazarus.

I wish to gratefully acknowledge the help and encouragement received from my wife, Carol, and also our children. This book could not have been written without them.

# FOREWARD

**The Book of Chemical Crisis** is a sensible, useful book. Mr. Sours has developed a crisis management model that effectively bridges the areas of substance abuse and the previously rather unorganized area of crisis intervention.

Mr. Sours correctly recognizes that individuals take chemicals in order to alter or reduce unpleasant emotions, and he appropriately considers the cause-and-effect relationship between emotions and physical behaviors.

The author's clear four-step crisis intervention plan and the crisis alternatives model can be readily incorporated into drug counseling programs. Addressed to the specific needs of chemical abusers, the book correctly identifies the basic knowledge and skills counselors need to work effectively with them. **The Book of Chemical Crisis** can be used to reduce inappropriate referrals by exposing counselors to a variety of treatment modes and available services.

As a physician, I am particularly impressed with Mr. Sour's unique discussion of hallucinations as a reinforcing behavior as opposed to a consequence of disease processes.

I think that significant gains in the field of chemical abuse and crisis intervention counseling would be made if **The Book of Chemical Crisis** were made required reading for all drug and rehabilitation counselors.

Maxie C. Maultsby, Jr., M.D.
Professor of Psychiatry
Director, Rational Behavior Therapy Center
University of Kentucky College of Medicine

Persons who work with substance abuse problems too often take a unidimensional view of causation and a similarly single-faceted approach to their solution. Floyd Sours, drawing on many years of experience as a clinical psychologist and as an expert in the field of substance abuse, offers us a more complex view of these problems, but one which, in my opinion, comes closer to capturing the reality of the people who suffer them.

He has written a book around the thesis that different people use chemicals for different psychodynamic purposes, and, therefore, need different kinds of interventions when they are in crisis and come to the attention of substance abuse counselors. It is eminently sensible to recognize that persons using chemicals to achieve different ends will not be inclined to give up their use unless less destructive alternatives are offered that will work to meet the same ends.

**The Book of Chemical Crisis** develops this thesis lucidly and in terms that will be familiar to the average substance abuse counselor. The author even includes an illustrative one-act play to bring additional clarity to the concepts that he discusses in the main body of the book.

Sours offers his readers detailed descriptions of the three personality-types that are most often seen in substance abuse crisis centers, goes into the basic life issues and characteristic methods of dealing with internal and external stresses of each, discusses the role that chemicals play in helping them to buttress and potentiate their defenses, and, based on an understanding of what each is trying to accomplish with their habitual patterns of behavior, makes specific recommendations about the kinds of interventions that are most appropriate.

**The Book of Chemical Crisis**, with its numerous tables and charts to assist the counselor as he goes through the steps of gathering information, evaluating the personal bases for the clients' problems with chemicals, and making decisions on what kinds of referrals and direct interventions ought to be made, will be welcomed by counselors who wish to add to their clinical perspective and increase their effectiveness in meeting the needs of chemically dependent clients.

Donald F. Tatro, Ph.D.
Clinical Psychologist in Private Practice
Phoenix, Arizona

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# ACKNOWLEDGEMENTS

I must admit at the outset that I did not envision taking nine years to write a small book on alcoholism and drug abuse. In fact, at first it seemed like an easy task that might be finished in a few weeks. But low and behold I was smitten with "writers cramp" and a multitude of other uncertainties, only to see weeks drag into years. Further, when the rough draft of the manuscript was finally ready, the criticism forecoming from my friends seemed devastating. So there I sat, thinking I had a worthless manuscript and no talent for writing.

But that was a few years back. Since then my friends have become more accepting of my work (after numerous extensive revisions) and the endorsement letters are still rolling in. Looking back on it, I must confess that the whole thing would never have been completed were it not for several key people.

I am particularly grateful to both Maxie Maultsby, Jr., M.D., and my old mentor and friend Don Tatro, Ph.D., whose endorsements and sage advice contributed much to the content and promotion of the book. I particularly am appreciative of the thought provoking discussions and arguments in the late 1960's

with my past clinical supervisor, Dr. Tatro. It is now clear that many of the ideas put forth in this book were first entertained there.

There are also a number of other persons who have reviewed and commented on the manuscript. They are 1) David Skeen, Ph.D., Associate Professor of Psychology at Muskingum College, 2) Jean Kirkpatrick, Ph.D., Director of Women for Sobriety, 3) The Reverend James S. Rila, Ph.D., a Presbyterian Minister and Chairman of the Eastern Ohio Regional Alcoholism Council, 4) Paul Lanham, M.P.H., Chief of the Ohio Division of Alcoholism, 5) John Bohley, ACSW, Director of the Mid-Ohio Alcoholism Rehabilitation Center, in Cambridge, Ohio, and 6) Anthony Sheposh, M.A., Director of the Jefferson County Drug and Alcoholism Center in Steubenville, Ohio.

Aside from that, typing was done by my secretary, Sharon Walker, and my wife Carol. Editing was done by Miss Mary Stone, a retired Cambridge school teacher, and by John Bohley, ACSW. The cover and illustration of the book was done by Debbie Weekley.

It should also be mentioned that the Drug and Alcohol Inventory in Appendix B is primarily an adaptation from Arnold A. Lazarus' **Multimodal Behavior Therapy**, New York: Springer, 1976, but some parts were also taken from the Jefferson County Drug and Alcohol Center's Inventory. Furthermore, the chart in Appendix C is printed in its entirety from an unpublished paper that was presented to the staff of the Mid-Ohio Alcoholism Center by Ellen Emmer, BA., MN,, MS,, in inservice training. Last but not least, thanks go to all of Dr. Maultsby's Rational Behavior Therapy Center Staff and the Staff in my own Regional Alcoholism Administrative Office have all been very supportive of the material in this book.

Floyd Sours, MA
August, 1980

CHAPTER 1

# INTRODUCTION

For a good many years I have had professionals in the field of Alcoholism and Drug Abuse approach me with questions concerning the way to handle the various ongoing crisis situations encountered in the field. Current literature on the matter has been largely useless because of the lack of agreement on the basic elements of crisis work. Still, for persons with experience it is clear that good advice can be given as each crisis situation occurs. That suggests that there is something more important to say on the subject, but judging from the literature, it apparently has not yet been said. Some time ago, based on such a need, I embarked on the task of writing this book in the hope that I could contribute something of value to my field.

The following pages are not meant to be unalterable pearls of wisdom so much as a loose framework by which each crisis worker may make independent creative judgments based on the unique crisis situation as it occurs. In this way, the uniqueness of each crisis is not lost in a stifling panoply of uniformity which is neither innovative nor in the best interest of the person-in-crisis. This loose framework is intended as an extension of the crisis

worker's experience and may rightfully be included as one of his "tools of the trade." This framework, or model as we will call it, consists of a few simple crisis assumptions about chemical use and abuse. Furthermore, special crisis situations involving hallucinations and polydrug use, as well as a section on treatment and referrals are discussed, using the behavior types. The last chapter deals with interpretation and use of the model using the one-act play in Appendix A.

In order to fully understand the content of this book, one must know that the central premises of the chemical crisis model are . . .

1) that individuals take chemicals in order to alter or reduce unpleasant emotions.
2) that individuals have unpleasant emotions which can be altered or reduced by the kind of behavior in which they engage.
3) that individuals can multiply the effect that behavior and chemicals can have on their emotions by utilizing both together (potentiation).
4) that individuals can engage in **new** behavior which can produce the same emotional effect as ingested chemicals, old behavior, or both.
5) that individuals who hallucinate, do so to reduce the intensity of their unpleasant emotions rather than to alter them.

It is assumed that these premises are only valid when the individual is not physically addicted to ingested chemicals. The behaviors described in the premises are also categorized into three general kinds so that a crisis worker may, by identifying an individual's behavior, obtain additional information regarding his emotions and possible appropriate referrals. The three general kinds of behavior are:

1) Impulsive Behavior
2) Withdrawn Behavior
3) Social Behavior

Each of these behaviors and their uses are described in the following chapters. It is also important to note that there are an infinite number of specific behaviors which an individual-in-crisis may utilize from situation to situation. Each of them have specific

mood altering qualities of their own and fall into one of the more general behavioral categories discussed here. I have dealt only with the more general behavior categories in this book, and will reserve the topic of specific crisis behaviors for another time.

In order to fit this crisis model into a practical crisis situation, part of this book also describes the steps a crisis worker should undertake in a crisis. They are as follows:

1) establish rapport and a trusting atmosphere by staying in the present.
2) gather information.
3) devise a plan.
4) take action based on the plan.

With these steps, the chemical crisis model can then be applied by using the appropriate tables or charts as the crisis worker devises his plan. It is hoped that the following pages will provide a useful guide and that it will enhance your already plentiful (but loosely organized) knowledge of drug and alcohol crises. It is suggested that the play in Appendix A be read carefully before beginning the next chapter in order that you gain a full understanding of this book's content.

## CHAPTER 2

# THE CHEMICAL CRISIS MODEL

To date, few if any, existing alcohol and/or drug programs have tried to develop a single conceptual scheme which would serve as a general guide for emergency decision making. The result seems to be the development of a vast array of techniques for handling brief encounters, without the similar development of a set of ideas designed to give continuity to these techniques.

Generally in treatment settings the idea of alternatives to chemical dependence describe a new developing general model for alcohol and drug abuse treatment. This model proposes that people today take certain easily abused chemicals in order to alter their moods. It implies further that if a situation or act were introduced into these peoples' lives which produced the same mind-altering effect, then there would no longer be a need for the use of chemicals. Of course this presupposes that when people undertake any kind of action it effects the way they feel in some way. For instance, a depressed person may engage in strenuous and aggressive athletic activity only to find that he no longer feels depressed. It is also assumed that none of the persons about whom we're talking are actually physically

addicted to the chemicals they are taking. This type of approach to drug and alcohol abuse treatment has fostered an emphasis on **information** as a basis for making decisions, on **actions** as a means to effect people's lives, on immediacy and the present to help establish **rapport**, on **planning** as a means to consider alternatives, and on the development and use of **community** resources as alternatives.

The drug and alcohol abusers however, are most often seen in crisis, and often will not commit themselves to the long term counseling for which the model was designed. It is a contention of this book that the "alternatives" model can be more appropriately applied to Crisis situations, since more of the elements of the model are met in crisis than in a treatment setting. Furthermore, it is proposed that alcohol and drug abuse centers train their staff for crisis and short term counseling using the more specific chemical crisis model which is described in this book. In order to further elaborate the idea of a chemical crisis model which is a practical extension of the old more general alternatives model, it is necessary to discuss each of the following elements of crisis planning.

In drug and alcohol emergencies professionals and paraprofessionals alike have sometimes been unable to obtain needed information or have been given misleading information because they could not establish **rapport.** An emphasis on the immediate situation and an appreciation of how the person-in-crisis feels can be all important in gaining his trust. Aloofness and a know-it-all attitude coupled with playing the role of the "man-in-charge" could blow the whole situation. The drug and alcohol abuser in crisis is frequently turned on by people who are direct and who participate in the relationship. Being in and participating may require responding to the immediate, without mental withdrawal from the situation. In stark contrast to the scientific distance which some professionals advocate as a method for identifying underlying conflicts, real rapport dictates actual participation in the emergency to the extent that the person-in-crisis will allow maximum self-disclosure quickly. This participation, in itself can sometimes change the mood of the person-in-crisis if part of the problem is related to that person's own feelings of isolation or depression. Such small upturns in

moods during crisis often are long-remembered and can be the basis for serious commitments to longer term counseling later. It is for these reasons that the crisis worker's participation in the crisis situation may be described as an immediate alternative to mood altering chemicals for the client in-so-far as that act itself creates the same upswing in the mood that ingesting chemicals produced. As you will see later, there are an unlimited number of acts which offer viable alternatives to alcohol and drug abuse. Some of these acts are initiated by the crisis counselor, while others may involve referral to another individual or agency who then becomes responsible for initiating action.

Prior to making any decisions about a crisis, any and all possible information must be obtained. Usually the most information will come from the person-in-crisis himself, but sometimes other agencies or individuals are available. Since the crisis worker ordinarily has little or no idea about the reliability of the information he gets, it is important to compare the views of as many different people as possible regarding the same event. It is also important to get some kind of intuitive "feel" for the kinds of people in crisis, who are most reliable. I have also found it useful to ask the person-in-crisis about an event that I have prior knowledge of, in order to get some idea of that person's reliability. Usually the information obtained covers personal information, historical information, and the crisis information. That information which is personal involves the person-in-crisis' private life and/or his relationships to significant people in his life. Historical information is not as easy to obtain in a crisis because it deals with the past and often involves other agencies or organizations. However, it is frequently useful in helping to understand the crisis. Such information involves the person-in-crisis or his family's past relationships with the community in which he has lived. The last kind of information is perhaps the most important of all; information about the present crisis. All three kinds of information are described in the last section of the book titled, "Interpretation." There is also a Drug and Alcohol Use Inventory in Appendix B in the back of the book which may give you some idea of the questions which may need to be asked in order to get the needed information. The history usually contains a drug use inventory, a medical history, descriptions of

past accidents, as well as descriptions of all arrests. Throughout the crisis interview, I further recommend that no notes or questionaires be filled out in the presence of the person-in-crisis so the crisis worker will not seem overly formal. Instead, a spontaneous give and take should occur between the interviewer and the one interviewed. After the session is past, the details should be commited to paper.

There are many crisis situations which call for immediate resolution. Often knowledge of local community resources, and of the crisis situation will help you and the person-in-crisis to devise a short term plan that will help alleviate immediate environmental stresses, as well as provide alternative courses of action. Since the plan usually is devised in emergency situations for very short lived purposes; it should be flexible and amendable to change as new information becomes known. All too frequently the drug or alcohol abuser has lived a moment-to-moment life too long and does not think any more about the consequences of his or her actions. For this reason, the plan should be simple, highly specific, and not cover much more than a one day time span. It should, at first, be designed to give the person in crisis some immediate tangible results, if possible, with a minimum of commitment on his or her part.

It is important to get accurate information regarding the events which led up to the crisis as well as to acquire any other pertinent information which is volunteered. Then, using the model, a decision must be made and action taken to help alleviate the immediate problem. In line with the chemical crisis model, the **action** by the crisis worker should be designed to:

1. provide alternatives to the present life choices presented in the crisis situation.
2. help reduce the immediate environmental stress of the crisis situation.

It should be kept in mind that an **action** may be any of the following:

1. An **action** may be direct confrontation with the person-in-crisis in order to alter his present unpleasant state of mind by changing the way he thinks about things.

2. An **action** may be transporting or arranging transportation to a facility which can provide a service which may lead to a viable alternative to his present choice in this crisis situation.
3. An **action** may be a decision to plan a course of action for the person-in-crisis, and to leave the responsibility for carrying it out with that person.
4. An **action** may be a decision not to take action, and instead leave things as they are.

There are usually a large number of services available in any given community. Some of these services are available to alcohol and drug crisis situations. Many of these services are not known to the general public. Many communities have county or city directories available which give the addresses and phone numbers of local agencies that provide human services. If there is no such directory in your area, you should contact your local crisis hot-line, your local drug and/or alcoholism center, or your local mental health center for a list of organizations who sometimes provide services to alcoholics. The following list of possible resources was extracted from an unpublished survey which was conducted recently in a nine county area in Eastern Ohio.

1) Hospitals.
2) Welfare Agencies.
3) Family Services.
4) Clergy.
5) Catholic Services.
6) Salvation Army.
7) Children's Services.
8) Good Will.
9) Health Departments.
10) Law Enforcement Agencies.
11) Bureau of Vocational Rehabilitation.
12) Schools.
13) Community Action Commissions.
14) Alcoholics Anonymous (A.A.).
15) Private Professionals.
16) Women for Sobriety (W.F.S.).

It is your job to know what services are available in your community and to utilize them in the best way possible as you handle each crisis.

Traditionally the crisis behavior of drug and alcohol abusers has been thought of as a symptom of an underlying mental conflict. The act of abusing chemicals too often is thought of as a symptom. Crisis interventions are all-to-often aimed at identifying the underlying problem, and the importance of the symptom or present life crisis is minimized. Often counselors using the traditional ideas appear to the person-in-crisis unduly detached, uncaring, and uninvolved. The result may be an intensification of this person's feelings of alienation and loneliness. Counselors working in drug and alcohol crisis situations should attend to the present situation in order to identify immediate needs. I also recommend establishing a solid relationship which can be utilized to quickly enhance the person's mood, thereby sometimes averting tragic action, like attempted suicide, homicide, or other acting-out behavior.

If the traditional Freudian theoretical framework is compared with the chemical crisis model, it is seen that Freud's system **mostly** refers to intra-psychic conflicts while our model directs itself specifically to problems between individuals-in-crisis and the community (inter-personal conflicts). The Freudian system only touches on the subject matter of our model when it refers to the phenomenon of "object cathexis." While there are a number of other interpersonal theories which center around conflicts between the individual and culture, none are specifically designed for drug and alcohol crisis situations and seem to be too all encompassing and philosophical to be of much use. In my opinion, this conflict between the individual and the community can best be solved by examining the behavior of the individual-in-crisis as he operates in the community, with his behavior being the vehicle for interaction in the community.

It seems to me that most persons inner mood states, and their behavior are closely related to one another. Further, it is my opinion that there is an even closer relationship between inner mood states and behavior for many alcohol and drug abusers. While most people are able to "temper" their urges through forethought, many drug and alcohol abusers "use" their

behavior to alter moods. In fact, in some cases their entire lives may be seen as an attempt to alter an inner mood. Their thoughts regarding these actions frequently occur "after" the act, and can be seen as an attempt to justify the action rather than to "temper" it. This need to justify is often seen as denial by those near the abuser. The result may be practically indiscriminate acts which serve the private purposes of the individual instead of the social conventions of society. For the alcohol and drug abuser, the pain of social deviance can frequently be offset by the satisfaction obtained from the inner alteration in mood. Hence, it may seem an effort in futility for society to try to change the abuser's behavior. The ever reoccurring conflict between society and the chemical abuser can be solved temporarily by ingesting alcohol or other easily abused drugs. In this way, moods are sometimes altered without developing concurrent problems with the community around them. On the other hand, more intense altered mood states can be produced when anti-social behavior and chemical abuse both occur simultaneously. In the latter case, we may say that the two events have produced a "potentiated" inner mood. The intensity of this state is greater than the sum total of each separate event.

Our model then proposes that all drug and alcohol abusers in crisis utilize chemicals to alter an inner mood, providing they are not physically addicted. Further, it proposes that many of these people utilize impulsive behavior to alter their inner state of mind. As these people persist in their behavior in the face of community efforts at restraint; the use of chemicals for mood altering purposes may become more and more appealing. On the other hand, simultaneous use of impulsive behavior with mood altering chemicals may reinforce the altered inner state. In either case, impulsive behavior is involved.

There are also people who are **not** in trouble with society, but who still are seen in crisis for alcohol and drug problems. We know that the proposed impulsive behavior is not characteristic of them. It appears that the individuals we are speaking of are either not behaving at all, or are behaving according to the communities rules and regulations. In other words, they are either withdrawn from or behaving within society's norms. It is proposed that while many people seen in drug and alcohol emer-

gencies will exhibit impulsive behavior, a substantial number will also utilize the withdrawn or social behaviors.

It is proposed that the following three kinds of behavior may be seen and/or deduced in drug and alcohol emergency situations.

1) Impulsive Behavior
2) Social Behavior
3) Withdrawn Behavior

It is important to note that according to the chemical crisis model impulsive behavior is closely connected to an inner mood state. Furthermore, the purpose of this behavior is to alter inner moods by using that close connection. In contrast, individuals exhibiting appropriate social behavior are more concerned about affecting the world outside with their behavior in order to obtain their share of satisfaction through social approval. This individual has a measure of control over what he does and is more able to think about how he feels and what he can do about it. In large part, this person's knowledge of the world around him will dictate which actions will become manifest and which will remain undone. In sum, by forethought he is able to reduce somewhat the close correspondence between his moods and behavior. In the case of the withdrawn individual, imagination is all that exists, without any corresponding realistic awareness of the world around him. When behavior does occur, its only purpose is to express directly the inner state and is therefore likely to be uncontrolled and/or inappropriate. On the other hand, for the impulsive kind of person, his search is often for the alleviation of an unpleasant inner state without concern for the social consequences. For the person who exhibits social behavior, concern over the kind of actions which should be taken, along with an awareness of existing unsatisfying states of mind are observable. His purpose then is to surmount obstacles in the community at large, thereby acquiring satisfaction by obtaining rewards offered by society (ie: praise, status, recognition). The withdrawn individual, on the other hand, is someone who has chosen to express only his inner feelings with no earthly purpose whatsoever in mind. In fact, even the purpose of choosing behavior for altering inner moods is discarded. What is left is a "straight-pipe" where moods occasionally manifest themselves

n behavior unrelated to conventional social norms. Considering this, it is easy to understand why behavior for this person becomes less and less frequent, as more and more punishment is handed out by society. Thinking and feeling has become a closed shop then, where no outsiders enter, as this individual withdraws. There is no real world outside, only the inner world of dreams and sensations. The close connection between feelings and behavior which was described earlier for the impulsive individual still exists theoretically for the withdrawn, but there is no earthly purpose to the rare behavior that is exhibited. The highly imaginative but sometimes bizarre thoughts and behavior of the withdrawn person-in-crisis have mind altering qualities of their own. For this reason then, I propose that many persons who consistently exhibit withdrawn behavior do not find much need for the mind-altering effects of chemicals. For those who do exhibit such chemical dependency, their use of chemicals is more a response to the punishment meted out by society, than anything else. It is important to note that people may utilize withdrawn behavior in drug and/or alcohol crisis for any of the following reasons:

1) They may never have learned to utilize behavior of any sort, and therefore have always been withdrawn.
2) They may have had such societal resistance to whatever behavior they exhibited that it was exhausted; the result being withdrawal.
3) They may have behaved perfectly well, but were so overwhelmed by immediate tragedy that withdrawal was necessary.

In the first case, serious problems will probably develop in establishing relationships that will make things difficult for the crisis worker. Similarly, serious problems in the behavioral area may develop in the exhausted type after the relationship has been established. However, withdrawn behavior caused specifically by the crisis may be dealt with very effectively by the crisis worker. In working with all kinds of withdrawn individuals, it should be kept in mind that they prefer the withdrawn state to the use of drugs as a way to alter their state of mind.

At this point it seems that both impulsive and withdrawn behavior are in the service of inner states without much concern for the outside world. In addition, person's-in-crisis who exhibit withdrawn behavior may be in-frequent users of chemicals.

Social behavior, unlike the other two, focuses on effecting the outside world through appropriate behavior. If this individual using social behavior is unable to effect the world by his behavior, then the mood altering effects of alcohol and drugs may be become more appealing as a way to change that unsatisfying state of affairs. Infrequent cases may also occur where an individual is behaving according to the communities social norms, but is not receiving the usual praise or status that is awarded. In such a case, the source of the problem is in the community instead of the individual-in-crisis. In fact, each of these three types of crisis behavior assumes a sane and just social order. As you will see, this is not always the case. Specific elements within society may at times be viewed as unjust, unfair, and unreasonable. In crisis, it is extremely important for the crisis counselor to assess the circumstances as well as the individual, to see whether crisis is caused by oustide events, the person-in-crisis, or both.

It is also clear that the close correspondence between the moods and behavior of impulsive behavior is less true for the other two types of behavior. In the case of withdrawn behavior, there appears to be no behavior at all much of the time. While the close correspondence can be hypothesized, the **lack of behavior** nullifies the direct expression of moods through behavior. This also makes it very difficult for the crisis worker to make inferences about the person-in-crisis' emotions. In the case of that person exhibiting social behavior, it is clear that his thinking process intervenes between moods and behavior thus reducing their close correspondence. As a result, neither withdrawn nor social behavior is as effective as impulsive behavior for altering emotions.

It should be mentioned here that persons-in-crisis who utilize withdrawn or impulsive behavior are difficult to work with because they obtain their satisfaction from within themselves, and are not concerned much about the satisfaction that culture can offer. It is speculated that some sort of meaningful interface

with a sane community is needed which presents some real life alternatives. Of the two behaviors, impulsiveness wins over withdrawal as least difficult to work with in crisis situations, since there is some sort of social interaction with the community. The person exhibiting withdrawn behavior has, for the most part, chosen not to interact, making short-term relationships and rapport very difficult to establish. On the rare occasions when this person exhibits behavior, it is without purpose and in the service of his moods.

It seems that we are actually looking at several different philosophies which individuals-in-crisis use in their pursuit of happiness. The behavior types reflect the vehicle that these individuals use to express their philosophies, since behavior is a means to effect or change the outer world, as well as a method for altering an individual's internal feeling states. It is now necessary to explain how they develop.

Let us assume that as each child grows, he experiences stimulation of varying sorts from the outside world around him. Furthermore, this stimulation, which often results from the actions of others, produces feelings within the child. Given a basic unpleasant feeling, each growing child then learns different activities to alter this inner state. As a result of learning to respond to outside stimulation, conscious awareness of the outside world is developed. Those activities which prove most successful in altering feelings will be the basis for thoughtful consideration of how best one should live life. It is easy to see then that people first learn to respond somehow to the outside world, then they develop conscious awareness, and lastly develop thoughts, beliefs, and philosophies. It follows then that the kinds of ways people learn to respond, will be the basic data from which beliefs and philosophies develop. In a way then we are what we do, since out thoughts were conceived from behavior originally. It is the intent of the rest of this section to describe in more detail the different kinds of behaviors together with the underlying philosophies which may be inferred from them.

For each of the previously mentioned kinds of behavior, it is assumed that the crisis is precipitated somehow by the person-in-crisis, and that the rewards meted out by society are just and fair. Actually, the possibility exists in each crisis situation that some

unfair or unjust element of a community, agency, or family may be directly related to the crisis. The first decision which every crisis worker must make about any crisis is whether the person-in-crisis or some other person, or agency is primarily responsible for the present circumstances. I would like to add that in the perfect society the individual would always be wrong, but who among us believes that any society is perfect. Ordinarily it will be necessary to work closely with the person-in-crisis but sometimes community agencies or individuals may appear to be unjust, or unwise, or uninformed. In such cases, it may be necessary to support the person-in-crisis and act as a change-agent in his behalf by contacting consumer advocacy agencies and/or other community groups which may be helpful in crisis resolution. On the other hand, if it appears that the crisis requires effecting the person-in-crisis and/or his immediate family, then it is necessary to decide which of the three types of behavior he exhibits before devising any plan of action.

The following summary statements and examples are listed in the hope that your understanding of these kinds of behavior will be enhanced.

1, **Impulsive Behavior:** Generally speaking, we are talking about anti-social acting-out behavior exhibited by persons-in-crisis. A definition well suited to the kind of behavior we are discussing is presented below:

> "... a subject behaving in such a way as to bring him to the attention of others (police, courts, school authorites, guidance clinics, psychiatrists, etc.) as a result of overt aggressive behavior ... our concept ... includes such activities as: instigating proceedings against others ...; robbing or swindling others; throwing objects with the intent of hitting (as a wife or husband in marital quarrels); (the school child picking fights with his peers or teachers;) violent destruction of bedding or furniture..." (Bricklin, Piotrowski, and Wagner, 1962).

At this point, it should be clear that the object of such behavior is the alteration of an internal state of mind. That being the case, it is no wonder that such persons show little concern about the

## Crisis Decision-Making Chart for Impulsive Behavioral Types

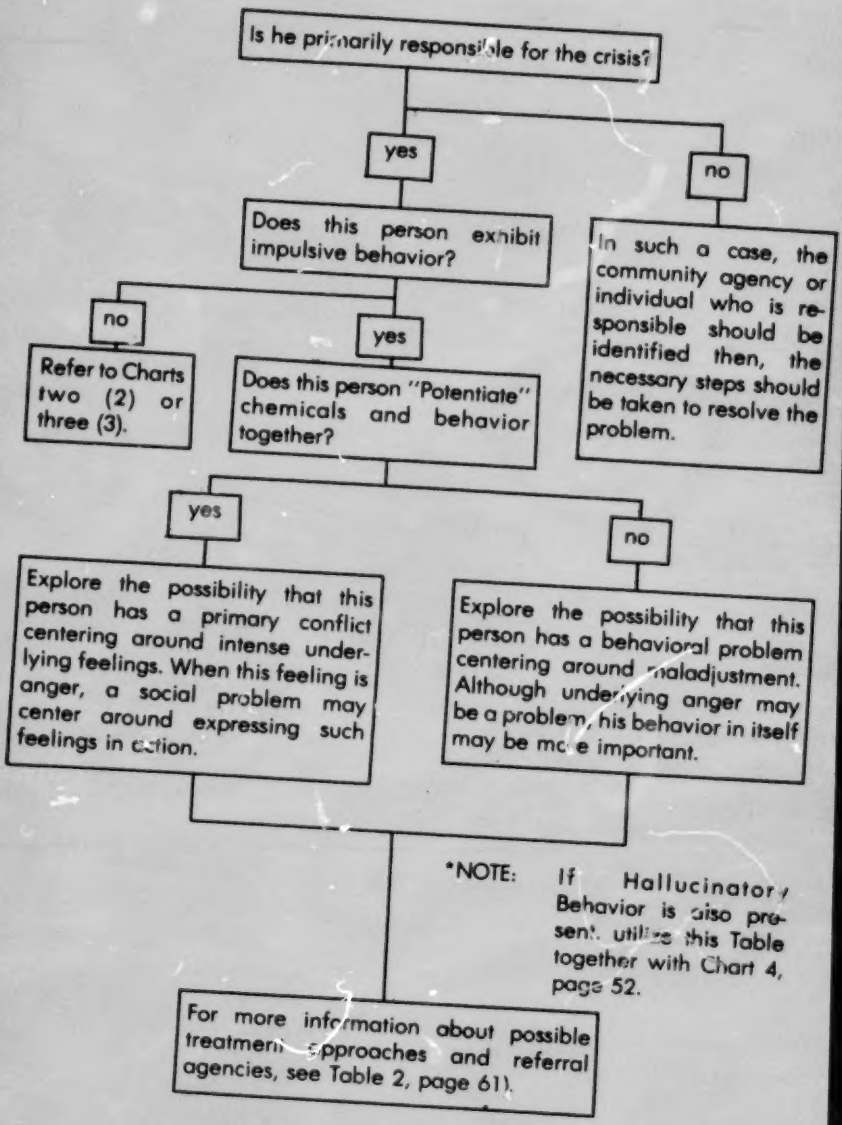


CHART 1



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punishments meted out by the outside world and persist with such behavior. In my opinion, the feelings which drive such behavior usually are anger or depression. Venting of such feelings in behavior frequently replaces an unpleasant state of mind with a more pleasant one rather quickly.

If a person-in-crisis has been described as exhibiting impulsive behavior, then it may be important to know whether he prefers to act-out under the influence of chemicals. If he does, then one should explore the possibility that he is "potentiating" his behavior together with the effect of drugs or alcohol much the same way that drug abusers use two chemicals together to multiply the effect. One can then speculate that this person may have a far more pressing need to alter his underlying feelings than someone who doesn't "potentiate." On the other hand, the use of behavior alone without the use of chemicals indicate primary maladaption and social problems with the mood altering qualities of chemicals being a secondary concern. Chart one (1) illustrates the entire decision-making process from start to finish for the impulsive behavioral type. A full one-act play in Appendix A provides a full characterization of the impulsive behavioral type. Although most of the behavior depicted in that play is impulsive, it should be noted that some withdrawn and social behavior is present. Both of these behaviors will be discussed in later sections.

It seems rather apparent that the various kinds of impulsive behavior encourage a certain philosophy of life which promotes thoughtless action. In fact, most children learn various kinds of thoughtless action at an early age as a response to outer stimulation. The child's behavior has both the potential for altering inner need states and for obtaining satisfaction from the outer world. For the impulsive type, alteration of internal states is the primary interest. Behavior is not used to obtain the praise of society. For example, a person exhibiting impulsive behavior would, upon seeing a pretty girl, respond by grabbing her and kissing her (or worse) without forethought. Such an unthinking response would certainly invite rejection by the girl or some other adverse cultural reaction. Impulsive types frequently continue to use such behavior as long as it continues to alter the feelings generated by the sight of the girl. It is clear at this point that the philosophy

and behavior of the impulsive type are related. While the behavior exhibited is most useful in identifying such persons in crisis, knowledge about the underlying philosophy is also useful. The impulsive philosophy encourages reckless responsibility within society and the direct expression of inner urges and feelings in behavior. This philosophy usually emphasizes the value of individual hedonistic pleasures, while de-emphasizing social responsibility and introspective character traits. Such a credo might sound like the following:

> "It may be noble in this primitive jungle world to live on promises of things to come, but as for me, give me the pleasures of today and the chance to be free of the pitfalls and dull routines which close in around most people. For me, excitement and adventure are my home. I want no dreamish rules and principles to pin me down. My ideals are those of the revolutionary leaders, who, ahead of their times, sat in prison because they spoke their minds. It is my belief that the world is largely a game, where the strong survive, and the weak are continually seeking devious ways to shape and control the strong. Commitment and close relationships are traps which are the means by which others seek to stop and control persons such as myself."

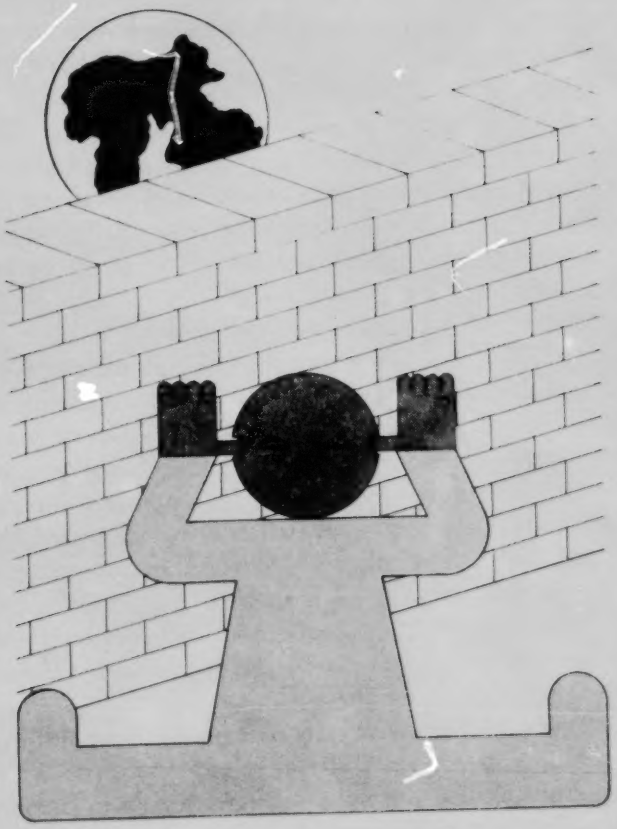
A crisis worker in a crisis situation should try to determine the person-in-crisis' philosophy of life, as well as the type of behavior which he exhibits or has exhibited. In this way, a more accurate determination may be made regarding which kind of primary behavioral type the person-in-crisis represents. An example of a crisis situation in which such a philosophy is identified is given in Appendix A, page 77.

2) **Withdrawn Behavior:** In general, this kind of behavior is utilized by people who, for one reason or another, cannot or will not respond to the world-at-large. The origins of such behavior lie in the early formative years of each child. Most children learn various ways to behave at an early age as a response to outer stimulation by the world-at-large. The child's behavior, as has been mentioned before, has both the potential for altering

unpleasant inner feelings and for affecting the outer world in some satisfying way. It is when a child learns to delay reacting or not react outwardly at all to outside stimulation, that these unpleasant feelings generate inner mental activity. In other words, behavior can be carried out as an outer activity in the world-at-large with the dual goals of effecting the outside world in ways that are satisfying, and of altering internal unpleasant feelings within the person-in-crisis. If that person chooses not to respond at all, mental activity may become the primary type of behavior which is used to alter his unpleasant feelings. In such a case, we would be seeing a person-in-crisis exhibiting withdrawn behavior. Most persons utilizing such behavior no longer respond well to stimulation from without, and instead use their inner imaginings to seek immediate relief from uncomfortable feelings. For example, in the previous section a situation was described in which an impulsive young man spied a pretty girl and responded by grabbing her and kissing her (or worse). A person-in-crisis who used withdrawn behavior would not respond. The unpleasant feelings associated with the outer stimulation (the pretty girl) would lead him to fantasize about winning the adoration and attentions of the girl. The result would be the experience of some satisfaction through mental activity without taking the risks associated with being recklessly impulsive.

As before, the crisis worker in a crisis situation must first decide whether the problems presented can best be solved by effecting the person-in-crisis or by effecting some other organization or individual in the community. If it is decided that problem resolution can occur best by working with the person-in-crisis, then it is important to decide which kind of withdrawn behavior is present (see Chart 2, page 37).

One type of withdrawn behavior refers specifically to persons who have responded recklessly and irresponsibly in the past to the world around them. Because of the punishment received for their actions, these persons soon exhaust themselves and no longer respond. Frequently persons exhibiting such behavior in crisis will be experiencing depression, appear lethargic, but seem well oriented. For the sake of clarity, this type of withdrawn behavior will be called depressed. Such depression is often generated as a result of reduced responsiveness to the en-



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WITHDRAWN BEHAVIOR

vironment. In that way, the actions generated under the influence of chemicals alter the person-in-crisis' depressed state of mind. Often the impulsive quality of such action initially create painful cultural reactions from the community. However, over time such behavior can be modified, particularly if effective counseling is introduced. It should be mentioned again that if the depressed withdrawn type is identified, underlying depression and reduced responsiveness should be explored as problem areas. Chemicals in this case are likely to be used mostly to reinstate old punished behavior (thus countering depression) as well as for the mind-altering qualities of the chemical itself. Both of these chemically induced effects together are likely to create a "potentiated" effect greater than either effect alone. The rule is: the more the effect the greater the need. So explore severe depression when you find "potentiated" interactions between behavior and chemicals (see chart 2) in withdrawn persons.

Traumatic withdrawn behavior refers specifically to persons who can not respond to the world outside because of the crisis situation which he is still experiencing. The important thing to note here is that the person's withdrawn behavior would disappear if the crisis were resolved. In such cases you will see person-in-crisis' who are non-responsive, maybe suffering acute shock and mild anxiety, but who are still well oriented. The crisis worker can do much to help such persons become more responsive, by providing support after establishing rapport. The most pressing problem in these cases is to identify key conflicts in the immediate crisis and provide as much problem resolution as possible (see chart 2).

The last type of withdrawn behavior is perhaps the most difficult with which to work. It is called historical withdrawn behavior because we are referring specifically to persons who have never in their entire life history learned to respond to external stimulation at all. Technically these people as children never learned to behave purposely at all. As a result, they have learned to utilize increased mental activity as a response to external stimulation. The idea of using behavior to effect the world in satisfying ways is never considered. Among this group are many long-term patients of mental institutions, as well as many odd or eccentric recluse types living in the community. Withdrawal is a

way of life for such people, and often can pose serious problems for the person-in-crisis. If hallucinations are present or are well documented in the history, possible psychosis should be explored. Although chemical abuse is rare in such groups of people, a crisis worker should consider the reasons why the person-in-crisis is suddenly seeking to alter his state-of-mind through the use of chemicals. It is possible that he/she is suddenly reaching out into the environment for help (see chart 2).

One of the real problems that crisis workers consistently have is identifying the behavior of persons who are chemically dependent. So far, in this book, three basic behavioral types have been identified, and the methods for determining each type are being discussed. The one-act play in Appendix A is primarily a description of the impulsive behavioral type. Still, toward the end of the play on page 81, Mrs. Sebring begins to describe her alcoholic son Harold as withdrawn the last few years. She describes him as not having any close friends, staying to himself, and frequently reminiscing about the past. Drinking, it seems, induces impulsive behavior in him. It is clear that Harold exemplifies the depressed withdrawn behavioral type at this point, even though impulsive behavior is still exhibited while he is intoxicated and under stress. Underlying depression is confirmed early-on as the curtain opens and Harold moans. The point of this example is that while Harold has a life-long problem with impulsive behavior, there is a more recent development which indicates depressed withdrawn behavior. In such a case, both impulsive and withdrawn behavior should be considered in devising a crisis plan.

While the behavior of the person-in-crisis is important, his philosophy of life is also useful in helping to determine which behavior type he exhibits. The philosophy presented in Appendix A page 77 is clearly the philosophy of an impulsive behavioral type, but does point out the potential usefulness of philosophies in general in determining with which type we are dealing. The following philosophy is offered as being representative of persons exhibiting withdrawn behavior.

> "There is much decadence in the world which arises from the selfish desires of unthinking people. I believe there is greater danger there, which

## Crisis Decision-Making Chart for the Withdrawn Behavioral Type

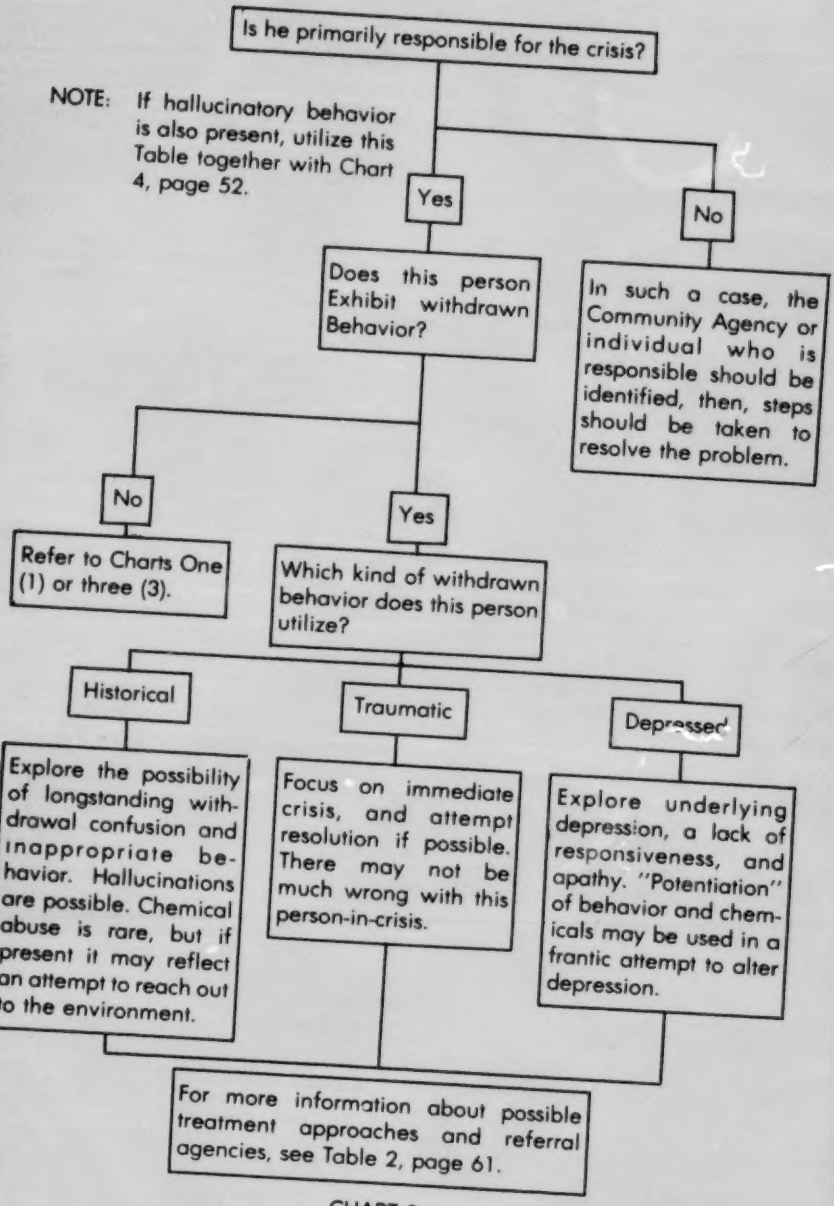


CHART 2

cannot be overcome. The forces of evil which exist must be resisted whether arising from within or without. However, there is some hope that by thinking the good thoughts; by discipling one's body and mind, and by abiding and following an enriched and fulfilled inner world, a satisfying life will be your reward by the "Grace of God."

When a philosophy which emphasizes non-involvement and withdrawal emerges in a crisis situation, one should consider the withdrawn behavioral type.

3) **Social Behavior:** This kind of behavior is utilized by persons whose purpose it is to obtain cultural rewards (ie: praise, status, recognition) which in turn produce satisfying inner states of mind. In other words, social behavior reflects the ultimate in responsiveness to the world-at-large, and in that respect differs radically from both impulsive and withdrawn behavior. It reflects an attempt at behaving appropriately socially in the belief that satisfying rewards will be bestowed by society on persons manifesting such behavior. Basic to this behavior is a deep faith that the world is fair if one follows the rules, and that one's fellow man is basically good if you get to know him well enough. In contrast to the recklessness of the impulsive behavioral type, the social type would, upon spying a pretty girl, delay immediate impulse gratification by thinking about the possible ways he might respond to her to establish a relationship. The kind of action he chooses occurs only after forethought. Forethought, in fact, is the means for delaying his responses. The kind of philosophy associated with such behavior might sound like the following:

> "I want meaningful relationships with other people as well as individual meaning and purpose in my life. I don't intend to spend much time alone, because there is so much to do and see in the world. It is important to understand and control my own destiny as I live my life in this world. It is my intent to be "Captain of my ship" as much as is humanly possible, at the same time knowing that there are others in this world with thoughts and feelings which deserve my respect. Like all

humans, I'm sometimes caught up in the tension created between my own desires and the press of reality. It is my hope that I am person enough to have a good grip on myself as I seek the satisfactions that this world offers. Success will not come by luck, but will be well deserved. In addition, I realize that it would be good to have an outlet for my own tender sentiments and even some vent for my darker emotions if suitable arrangements were made, and no one would be harmed by it."

It is clear from the preceding description that a person-in-crisis exhibiting such behavior is certainly "of this world" and adaptable. His history will be void of arrests and accidents, and only occasionally will counseling through public service agencies be evidenced. Still, individuals who manifest social behavior are, in varying degrees, successful in obtaining enough of these cultural rewards to sustain on-going satisfying states of mind. However, it is not uncommon to encounter individuals-in-crisis who have a sophisticated understanding of cultural expectations, but who still engage in chemical abuse. When such persons are seen in crisis, social maladjustment problems, heightened social sensitivity, and/or underlying feelings of inferiority may be key problems. In addition, chemical abuse is likely to center on alcohol because these people respect rules and regulations and are less likely to engage in illegal activities.

The play in Appendix A, for the most part, reflects a radically different behavior and philosophy from persons exhibiting social behavior. Still, Harold did function rather well in the community through the years; particularly when sober. Although he had an aversion to rules and regulations, he apparently followed them enough to remain in the community as a respected businessman. Therefore, although social behavior was not his primary style, he was still fairly well adjusted socially. Apparently, he used chemicals to create actions which altered his underlying depression and/or whatever other unpleasant feeling he lived with. When behaving socially, Harold apparently felt "caged" and could hardly wait to "bust loose." It is useful then to use the characterizations in the play to depict social behavior, even though the style of the person-in-crisis is not social.

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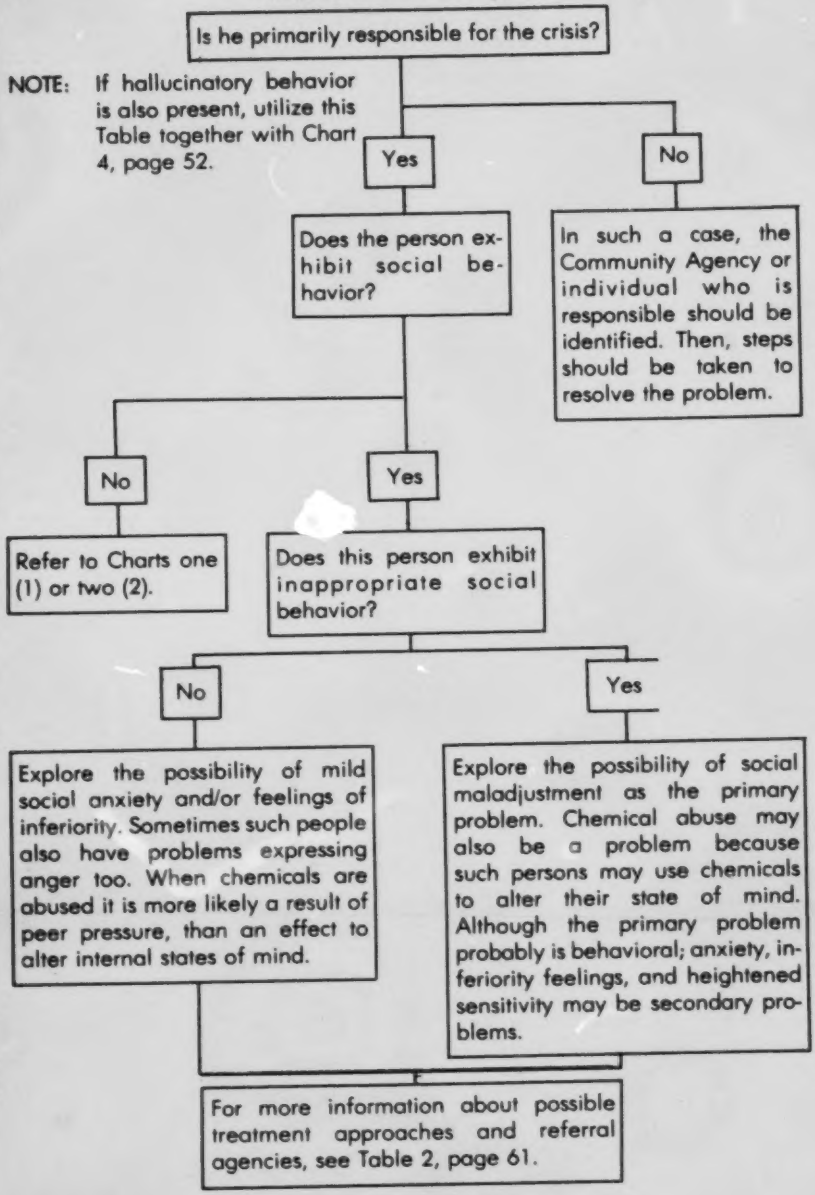
We've assumed that behavior descriptions and philosophies allow a crisis worker to identify the primary behavioral type of the person-in-crisis. If he exhibits primary social behavior, it is then necessary to make one more distinction between appropriate and inappropriate social behavior (see chart 3, page 42). Appropriate social behavior is behavior which is close enough to immediate cultural expectations so that on-going satisfying states of mind would ordinarily be expected. Hence, the mood altering effects of chemicals ordinarily are not appealing. When chemicals are used or abused in crisis settings, the chemicals are oftentimes not related to the crisis. More often than not such chemical abuse is the result of peer pressure and is recreational in purpose. Because of such person's interest in and sensitivity to people and the environment, they may suffer from mixed feelings of inferiority and social anxiety. Others may think of them as shallow, superficial, conforming or unassertive. It should also be mentioned that such individuals may behave appropriately and yet not experience the proper rewards. In such cases, a crisis worker should examine the social environment itself for the resolution of the crisis. (see chart 4, page 52).

On the other hand, inappropriate social behavior represents behavior which is unsuccessful in obtaining enough on-going cultural rewards to be satisfying. Often this failure involves some subtle misperceptions about what the immediate cultural expectations are. As a result, it is relatively common to encounter persons-in-crisis abusing chemicals who are concerned and conflicted about the world around them. In such cases, social maladjustment is usually the primary problem, with social anxiety, superficiality, and feelings of inferiority being secondary. It should be noted that the social anxiety, and feelings of inferiority are more intense and frequent than those described as appropriate social behavior. Chemical abuse in this case usually is no longer considered recreational, and instead is used to alter underlying feeling states. (see chart 3, page 42).

The chemical crisis model, as stated up to this point, presumes that the behaviors of alcohol and drug abusers are attempts to alter their inner state of mind, while the actions of the crisis worker are designed to help alleviate part of this present problem.

## Crisis Decision-Making Chart for the Social Behavior Type



I would like to add that aside from the preceding behavior types, there are some other types of behaviors which may be seen in crisis. For instance, an occasional hallucination may occur much to the surprise of the crisis worker. There are also occasional interaction effects between chemicals taken simultaneously which may confuse issues in crisis. The next two sections are designed to outline some methods for dealing with such problems.

## CHAPTER 3

# HALLUCINATIONS

The Chemical Crisis model as described earlier applies to hallucinations as well as to other types of behavior. The only difference being that hallucinations as actions generally serve to reduce the intensity of the underlying emotions, as contrasted to altering the actual content of emotions in the case of the other three basic types of behavior. Ingested chemicals can act directly on emotions to alter their content. Various combinations of behavior and chemicals can be used to multiply or "potentiate" the effect on emotions.

We have, up to this part, covered the types of behavior that will be seen in crisis by a perceptive crisis worker. However, occasionally bizarre behavior will erupt in the midst of crisis which does not fit the preceding categories. For simplicities sake, we shall call such behavior hallucinatory. If a hallucination is an internal perception which is heard, seen, or touched which has minimal external cause or stimulus, then the behavior that arises as a result of such a perception should be called hallucinatory behavior. Although there was some mention made earlier about the bizarre behavior that may accompany some kinds of

withdrawal; nothing has yet been said about the various kinds of drugs induced hallucinatory behavior and how they compare with other kinds of hallucinatory behavior. That subject has been left for this section of the book.

It appears that there are three kinds of reactions to alcohol which could produce hallucinatory behavior (see Appendix D). The first and probably the most common reaction seen in crisis is delerium tremens (D.T.'s). This delerious state may occur after prolonged drinking or during a period of abstinence, and is preceded by restlessness, uneasiness, apprehension, insomnia, and a heightened sensitivity to slight noises. When D.T.'s occur, the following happens:

1) the person-in-crisis becomes disoriented for time and place.
2) vivid concrete hallucinations occur which involve small fast moving animals.
3) the person-in-crisis experiences an acute fear of the animals in his hallucination.
4) the person-in-crisis becomes extremely suggestible.
5) the person-in-crisis exhibits hand, tongue, or lip tremors.
6) the person-in-crisis may also begin to perspire.

It should be added that if the crisis worker suspects D.T.'s, a referral should be made immediately to the nearest local hospital. While some communities have non-hospital detoxification services, most still do not. In addition, the drying out of an alcoholic who is experiencing D.T.'s is a difficult problem which calls for the services of a physician. It should also be mentioned that D.T.'s may occur with any of the three basic types of crisis behavior.

A second kind of reaction can be called an alcohol-related hallucination. Such hallucinations occur generally in persons with severe mental problems and only surface while the person is under the influence. If the crisis worker suspects that a person-in-crisis has an underlying mental problem of sufficient magnitude to produce hallucinatory behavior when drunk, a referral to the nearest inpatient psychiatric unit should be considered. It should be mentioned that treatment directed only at the underlying conflict will be ineffective unless other referrals

are made to the alcoholism centers, alcoholics anonymous or Women for Sobriety where treatment will focus on the symptom through the use of group pressure and/or behavior modification techniques. It is of upmost importance that comprehensive treatment include both the symptom and any underlying conflict or problems. It is also important to mention that a mental problem which illicits hallucinatory behavior when the person-in-crisis is drunk is likely to be associated with the previously mentioned withdrawn behavior type.

Last but not least, sometimes an alcoholic with Korsakoff's Syndrome will be seen in crisis. These persons seem to be hallucinating, but on closer inspection it can be determined that they are experiencing memory loss and are unable to form new associations. In addition, such persons frequently try to conceal their memory loss by falsification. This falsifying often leads to rambling tales and distorted associations. These kinds of alcoholics are usually older and more chronic, and frequently have tingling of the extremities. If Korsakoff's Snydrome is suspected, an immediate referral to the nearest medical facility should be made. Korsakoff's Syndrome could be associated with any of the previously described behavioral types.

There are also kinds of hallucinatory behavior which are related to the ingestion of drugs other than alcohol. Though there are many easily abused drugs other than alcohol, hallucinations mostly occur with hallucinogens or hypnotic sedatives. Since it is often virtually impossible to determine which drugs have been taken in a crisis, it is convenient to talk about the two categories of hallucinations that are related to other drugs as if the drugs in question are hallucinogens or hypnotic sedatives. They are thought to produce hallucinations more consistently than other easily abused drugs (see Appendix C & D). However, uppers sometimes promote paranoid delusions, while ingestion of hallucinogenic drugs and hypnotic sedatives do not. In addition, heavy users of cocaine may experience paranoid delusions with auditory and visual disturbances which are similar to hallucinatory behavior.

One kind of hallucinatory behavior which is related to the ingestion of drugs other than alcohol we will call drug-induced hallucinations. Sometimes hallucinations occur directly from the

ingestion of drugs (particularly hallucinogens and hypnotic sedatives). In order to identify such hallucinations and their corresponding behavior, it is sometimes helpful to examine the general content of the hallucinations as well as any external stimulus. For instance, in drug-induced hallucinatory behavior you may hallucinate to a record or film by seeing sounds or hearing sights. In either case, a minimal external stimulus is present (ie: the record's sound or the film's picture) and the content of the hallucination is vivid imagery with perhaps more movement than might be expected in most other kinds of hallucinations. These kinds of hallucinations, in spite of great variance in content material, are distinctly different from the rather concrete and simple hallucinations produced by delerium tremens (D.T.'s) in the mentally retarded and/or the organic. On the other hand, they lack the alien and bizarre quality, as well as the seeming lack of external stimulus, that hallucinations caused by intense psychiatric problems produce. It should be mentioned in passing that often, when the person-in-crisis is in withdrawal, hallucinatory behavior may also occur. A close inspection of that person's drug history will probably give the crisis worker new insight into which kind is occurring. In addition, sometimes short-lived hallucinations called "flashbacks" occur spontaneously in heavy hallucinogenic drugs users even though no drugs have been taken. In these cases the hallucinations will not be very intense and will disappear after a few minutes. In any case, drug ingestion coupled with hallucinations usually is a medical problem which requires medical attention, so a referral to a hospital is usually in order.

The second kind of hallucination is produced by an intense underlying psychiatric problem that only occurs when drugs are taken. We shall call this behavior drug-hallucinatory, as contrasted to drug-induced. Here, the same rules apply as in the case of alcohol-related hallucinatory behavior. As was mentioned earlier, a referral should be made to a psychiatric or mental health facility followed by a referral to a drug center which focuses on symptom removal. However, since any kind of hallucinatory behavior coupled with the ingestion of drugs is difficult to identify, a referral to the nearest hospital emergency room usually occurs first. Of course it is presumed that detoxifica-

tion is not necessary and no medical problems exist which need immediate attention. Hallucinations of this sort have a more bizarre content than alcohol-hallucinatory behavior and are closer to the hallucinations produced by persons with intense psychiatric problems with no drug or alcohol problems. They are less intense however, since the problems are contained most of the time by the person-in-crisis and only occur under the influence of drugs.

All of the aforementioned possible kinds of hallucinatory reactions to alcohol or drugs could be seen in a crisis situation. When present they could indicate a serious problem of some sort. However, there are a number of other conditions, which are not drug or alcohol related which also could produce hallucinatory behavior.

In crisis, a person's use of chemicals will occur sometimes together with the hallucination only as a result of chance. Such hallucinations (or states which seem like hallucinations) can be the result of medical problems. However, such hallucinations occur in crisis situations only rarely. They are rather difficult to identify because the crisis worker is usually looking for other causes for the problem. When medically related hallucinatory behavior does occur, it is most likely to be the result of "hardening of the arteries" (arterioschlerosis) in older people, or the shock reaction of diabetics who have stopped taking their insulin (insulin shock) or complications of the disease entity itself. Of course, there are numerous other possibilities and they are listed below from the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, (1968).

1) Hallucinations related to metabolic or nutritional disorders (ie: pellagra, avitaminosis, epilepsy, and metabolic disorders).
2) Hallucinations related to systemic infection (ie: pneumonia, typhoid fever, malaria, and acute rheumatic fever).
3) Hallucinations related to childbirth may occur at anytime during pregnancy and the post-partum period.

On the other hand, hallucinations associated purely with underlying mental problems, mental retardation, or brain

damage occur more often and can usually be identified fairly easily if adequate information is available. If any of the aforementioned is related to the development of hallucinatory behavior then the use or abuse of chemicals is very likely to occur independent of the hallucinations. That is, the hallucinations will occur with or without the ingested chemical. Furthermore, in the case of mental problems the hallucinations occur in response to inner need, and have little or no environmental stimulus to trigger their onset. Such individuals quite possibly will be withdrawn, alienated, have a poor work and family history, and exhibit very inappropriate even bizarre behavior at times. The content of such persons' hallucinations may consist of bizarre and unreal perceptions. When hallucinatory behavior is related to mental retardation or brain damage, the hallucinations most likely are related to the present stress situation and/or past environmental pressures for the individual to function beyond his abilities. Such persons may appear concrete, somewhat dull, and in the case of brain damage, uncoordinated. The content of such a person's hallucinations will probably appear to be simple, unimaginative, and sterotyped. In the case of mental retardation or brain damage, valuable information can be obtained in conversations with family or close friends. At any rate, when such problems are identified as primary (not related to drug or alcohol ingestion), a referral should be made to the appropriate community health service agency.

Let's say that crisis decisions have been made, and the person-in-crisis is not only the primary subject for crisis resolution, but has also been identified as one of the three primary behavioral types mentioned earlier. The new wrinkle is that hallucinatory behavior has also been evidenced. The first question an alcohol or drug crisis worker must ask in such a situation is "Do the hallucinations occur regularly together with chemical abuse?" (see chart 4). If the answer is "yes," then you no doubt have a problem complicated or confounded by the abuse of chemicals. If, on the other hand, no chemicals are involved your only responsibility is to make a proper referral. If next the crisis worker can determine whether alcohol or other drugs were abused, it is possible to go a step further in isolating the various conditions under which hallucinations and ingested chemicals

interact.

It is known that chemicals can produce hallucinations directly in persons, in a number of different ways. For instance, both delerium tremens and Korsakoff's Syndrome (see Appendix D for a more detailed description) cause hallucination-like reactions with continuous prolonged ingestion of alcohol. Such hallucinations reflect more the mental and physical deterioration resulting from alcohol abuse than anything else. Drugs other than alcohol, particularly the sedative hypnotics and hallucinogens can also directly produce hallucinations. Since many people have purposely hallucinated under the influence of drugs, the only inference that can be made from such an act is that they are curious about such drug use.

On the other hand, much of the time hallucinations which occur together with either alcohol or other drugs can be traced indirectly to underlying mental states. In such cases our chemical crisis model fits well, with some alterations. The ingested chemicals act as a catalyst for the diminishing of underlying unpleasant feelings as the feelings manifest themselves in hallucinatory behavior. Unlike impulsive, withdrawn, and social behavior, hallucinatory behavior represents a venting of emotion. The three behavioral types represent a more modulated and controlled form of action which alters the content of emotion. Hallucinations vent emotions, thereby reducing their intensity. We can assume then that the presence of hallucinatory behavior, when chemicals are used for their effect, implies the existence of underlying intense emotions of some type. Since confusion and disorientation seem to accompany many hallucinations, it is supposed that the persons-in-crisis may be intensely confused and disoriented, particularly if they are withdrawn. The particular behavior type which accompanies the hallucination can also be a help in determining what kind of underlying unpleasant emotions are being experienced by the person-in-crisis.

## Chart for Crisis Decision-Making For Hallucinatory Behavior

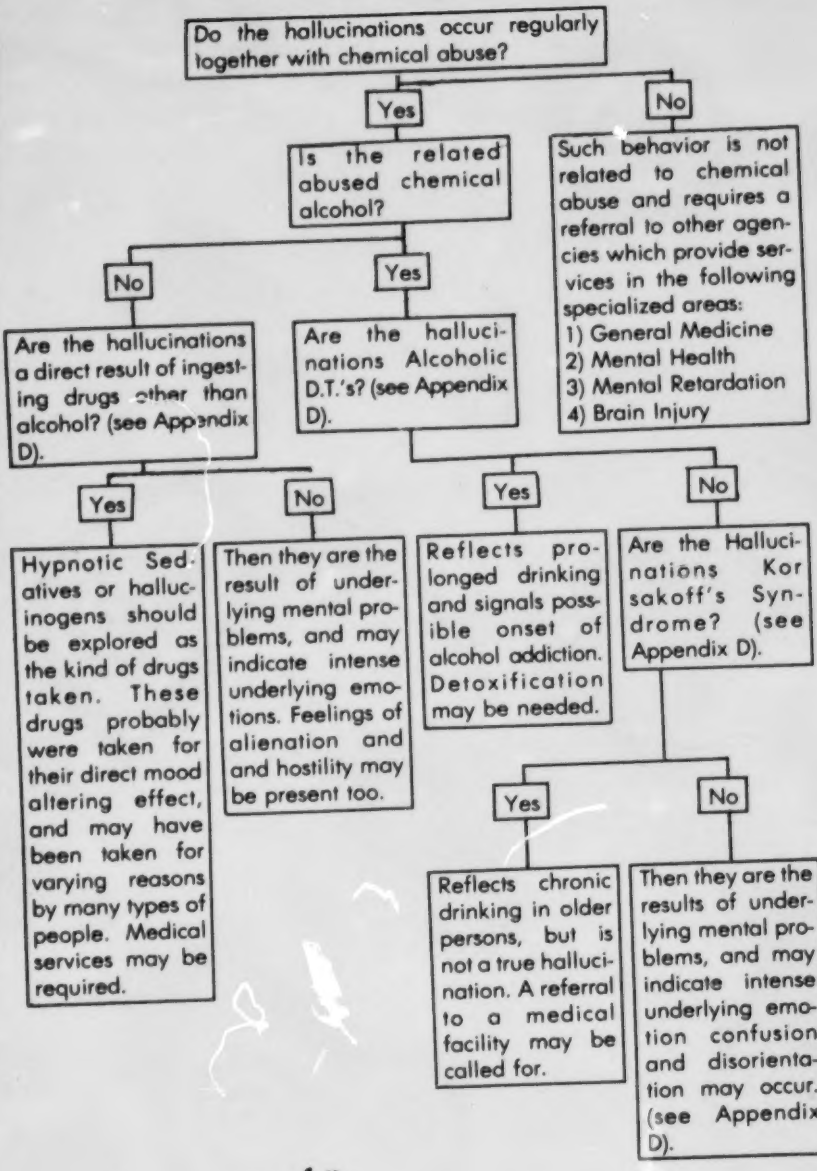





CHART 4

CHAPTER 4

# INTERACTION BETWEEN ALCOHOL AND OTHER DRUGS

Sometimes in crisis, because of a lack of historical or personal information, all a crisis worker will have to work with is lots of present symptoms. In such a situation, it is difficult to effectively use the chemical crisis model. However, frequently the symptoms themselves dictate the kind of referral that needs to be made. Interaction effects between simultaneously ingested chemicals can and do complicate the crisis workers' job of interpreting symptoms to make an effective referral.

In such a situation a crisis worker should first seek to determine whether that person is a polydrug abuser. It can be helpful to know that women and young adults are thought to be more prone to polydrug abuse. After that, as much drug history as possible should be obtained. Interaction effects between alcohol and other drugs should then be considered to explain any unusual behavior or symptoms. It is my intent to briefly explain the most serious and frequent interactions together with their symptoms, so that such symptoms will not be confused with some of the other behaviors or symptoms described earlier as part of the chemical crisis model. A more thorough description of such in-

teractions is available in the table in Appendix C.

A very dangerous interaction effect likely to be seen in crisis is that of barbiturates (sleeping pills) and alcohol (Crout, Gardner, Kennedy, Novitch, Parkman and Pines, 1979). Sometimes, physicians prescribe barbiturates for short periods of time to treat insomnia. However, persons-in-crisis may use them for prolonged periods of time to produce a sedative effect to bring them off a "high." Alcohol taken together with a barbiturate can multiply the sedative effect, and even cause death in some instances. With chronic heavy alcohol consumption, respiratory depression may occur, together with nausea (see table 1). If no other explanation is available to explain such symptoms, explore the alcohol-barbiturate combination.

Persons taking antabuse (disulfiram) as an aid to stop drinking are sometimes seen in crisis when they drink alcohol while the antabuse is still in their system. It may take as long as two weeks to get all the antabuse out of the body. If alcohol is taken together with antabuse by a person-in-crisis, the result is a toxic reaction which is initially characterized by facial flush, headache, the sensation of shortness of breath, nausea, and vomiting (Crout, 1979). (see table 1). Since this reaction can progress to convulsions and death, such symptoms should dictate a quick referral to the nearest hospital emergency room. It should be mentioned that some other drugs may demonstrate a similar type of toxic reaction with alcohol if taken in sufficient quantity. Water pills (diuretics), blood vessel dialators, oral anti-diabetic medications and some antibiotics, are some of these drugs. However, in chemical crisis situations such symptoms are more than likely to result of an alcohol-antabuse combination; particularly if the person-in-crisis is an alcoholic.

Major tranquilizers can be prescribed for serious emotional problems and psychosis. When they are taken with alcohol, additional depression of the central nervous system may result (Crout et al, 1979). Such an effect may result in impaired muscle coordination, poor judgment, and drowsiness (see table 1). Persons experiencing such symptoms should be encouraged not to drive or perform tasks which require heavy concentration. As long as the symptom of drowsiness is being discussed, it should be mentioned that most antihistamines also produce increased

drowsiness when taken with alcohol. Persons who have taken both chemicals together should not be encouraged to drive machinery of any kind.

## Table I

### Interaction Effects Between Alcohol And Other Drugs

| Drug Category | Interaction Effect |
|---|---|
| 1) Barbiturates | Nausea; respiratory depression; death sometimes occurs. |
| 2) Antabuse | Facial flush, headaches, sensation of shortness of breath, nausea and vomiting. |
| 3) Major tranquilizers | Drowsiness, poor judgment, and motor incoordination. |
| 4) Antihistamines | Drowsiness. |
| 5) Stimulants | Counteracts the effects of alcohol; look more alert than they should, but still have loss of coordination. Occasionally the heart can be overtaxed. |
| 6) Minor tranquilizers | Impaired performance. |

When individuals use stimulants like amphetamines, cocaine, or coffee, together with alcohol, unexpected reactions can occur (Crout, 1979). For instance occasionally the heart can be overtaxed to the point where it stops beating. Ordinarily, however, these persons look and feel less intoxicated than they really are, but their poor coordination and lack of judgment make them a menace on the highway (see table 1). Recent studies also indicate that minor tranquilizers (Librium, Valium, etc.), also impair performance when taken with alcohol, and are considered dangerous. Although there are a number of other interaction effects which exist, none are seen often enough in crisis to merit space here.

Before closing out this section it is important to state what information about chemical abuse is most useful, even though such information is not always readily available. Always obtain, if possible, the **names** of all drugs which were taken. From this information the group into which the drug falls can be determined from Appendix C along with the expected effect. The **amount** of each drug is significant because the larger the doses, the greater the expected effect. The interval between doses is important because substances taken simultaneously interact the most. It might even be important to try to gauge the intensity of the interaction effect from the person's body weight, since the smaller the size the greter the effect. Age can also be important; infants and the elderly are more sensitive to drugs. Finally, try to determine if the person-in-crisis is ill or has a chronic disease. A weakened body will handle drug interactions inefficiently or medication prescribed for a disease may complicate the interactions. (For more information on interview material, see Appendix B).

## CHAPTER 5

# REFERRALS

It is clear at this point that the previously mentioned behavior types are only useful insofar as they have application in a crisis situation. It is for this reason that this section is specifically devoted to the kinds of treatment and referral which come from using our model in a crisis situation.

In crisis, a crisis worker is most likely to encounter either impulsive behavior with or without intoxication. However, the withdrawn and social behavioral types will also be encountered. In fact, these three behavior types and the most likely type of treatment and referral will now be discussed (see table 2). It should be fairly clear at this point that impulsive behavior (with or without chemicals) is an attempt to alter an internal unpleasant state of mind without the proper regard or respect for social convention. In such cases, it is not uncommon for the punishment and/or advice given by significant persons representing authority to be entirely ignored repeatedly by the person-in-crisis. They are more concerned about altering their moods, than in receiving recognition, status, or praise. For that reason, such people are frequently written off as "poor prognosis" or as "in-

corrigible" or "delinquent." According to the crisis alternatives model described earlier if new actions or behavior could be introduced which produced the same mood altering effect as the chemicals and/or inappropriate behaviors, then there would be no need for them. In effect, that would amount to success in treatment if such behavior were reasonably appropriate.

Such an approach to treatment certainly involves a symptomatic approach. Apparently then, we are talking about behavior modification, role training, or some other approach which involves action as the recommended treatment approach (see table 2). If impulsive behavior is identified and an action treatment approach is deemed appropriate, most referrals would involve alcohol and drug centers since they are usually best prepared to provide such an approach. On the drug side, confrontation therapies with a Gestalt flavor seem to proliferate. Role training techniques also seem to be popular. With alcoholism, it seems that cognitive therapies which involve confrontation, behavior modification, or role training techniques are quite frequent. In both cases brief counseling is called for, since such persons oftentimes drop out of counseling within a few months. Amidst all these approaches there have been a few attempts to combine treatment modes. Dr. Maultsby's "Rational Behavior Therapy" (RBT) combines the best of the cognitive and behavioral approaches and does appear to have a promising future. I would like to add that some areas do not have separate drug and alcohol centers, and instead have combined mental health centers which provide the entire range of comprehensive services. In addition, some few areas have no drug and alcohol services at all. In that case, the nearest health center should be contacted.

Another frequently seen crisis behavior is depressed withdrawn behavior. Although this person-in-crisis appears unresponsive inhibited and/or withdrawn, historical information gathering invariably reveals past impulsive behavior. It is implied that the punishments meted out by society for impulsiveness have finally taken their toll, and his behavioral repertoire has become "exhausted." Frequently such people appear depressed and fatigued. Because there is no primary present behavior other than withdrawal (which is characteristic of

such persons) no potentiating can occur between chemicals and behavior to alter the depressed state. As a result, for purposes of behavioral classification, it doesn't matter whether the person-in-crisis has ingested chemicals or is intoxicated. If the chemicals are present and his state of mind is altered, but he is still unresponsive and withdrawn, his behavior is characteristic of depressed withdrawn behavior and his depressed internal state of mind will return later. On the other hand, if he is chemically intoxicated and he becomes impulsive instead of withdrawn, he is exhibiting a different kind of behavior (impulsive behavior with chemical abuse) and probably has a different kind of problem too. In any case, unresponsiveness and depression are a different kind of treatment problem and deserve a different approach than impulsiveness. Probably, the problem in treatment is how to get the person-in-crisis to respond once again to the environment, but this time more appropriately. In so doing, it is presumed that the state of depression that the person-in-crisis experiences will be altered or diminished by the new learned behaviors. The first and most important step in treatment is clearly to have the person-in-crisis respond someway. In addition, that probably will not be too difficult since he has responded in the past. In this kind of situation traditional insight therapies which involve verbalizing and conceptualizing past life events may provide sufficient motivation for renewed responsiveness to the environment, provided the whole counseling situation is handled carefully and the treatment is designed to be brief (see table 2). On the other hand, assertiveness or stress management training can also provide a useful present-oriented symptomatic alternative approach to treatment. The cognitive approaches in my opinion, generate too much conscious resistance to be very useful. After all, withdrawn persons are usually rather well defended from people trying to verbally effect them. I would like to add that role training and/or psycho-drama can be very useful, if you can get the person-in-crisis to participate. I should mention in passing, that that can be a big "if" sometimes. Rational Behavior Therapy can also be used here since it utilizes behavioral techniques as well as a cognitive approach. Family therapy can also be useful if the person's problems center around his family and he is willing to participate. Care should be

taken, if behavior modification is used, **not** to use aversive conditioning. It could cause further withdrawal. In terms of referrals, brief insight therapy, assertiveness training, stress management training, and family therapy are generally available through a number of public service agencies (ie: family services, mental health centers, drug and alcohol centers, etc.). More often than not, family and insight therapy are provided within mental health centers, while local alcoholism and drug centers seem to steer clear of insight therapy in general, but do provide some stress management and assertiveness training as educational services.

Traumatic withdrawn behavior refers to withdrawn persons-in-crisis who are withdrawn specifically because of the crisis. There is some of this kind of behavior seen in crisis, but in my opinion not nearly as much as the previously mentioned kinds of behavior. These people however, tend not to abuse chemicals outside of the present crisis and therefore usually do not have an alcohol or drug problem of long standing. In this case, there is no underlying mental problem except as a result of the crisis. As a result, the person experiencing the crisis returns to normal when it is over (see table 2). Obviously, this is a case for the crisis worker. Referrals may not be necessary here, if the crisis can be understood and resolved. The crisis worker really needs to understand the situation here, but probably will have minimal information. In addition, he may have no way of knowing whether the information he has is accurate. In a case such as this, it is of paramount importance that rapport be established with the person-in-crisis, and that information be obtained regarding both the present crisis, the person's past and his current mental status. If rapport can be established, information can be obtained first hand which increases the probability that the information is accurate. In addition, you then will have an opportunity to assess the person's mental state. That too will give you some ideas about how accurate his information may be. Then you can compare historical information about his past with the present information you have. Comparisons can tell you whether he's withdrawing, becoming more impulsive, or more socially appropriate. It is possible then, after information has been gathered, to make a direct very short term attempt to intervene

## Table 2
### Treatment and Referral Grouped By Behavioral Type

| Behavioral Type | *Treatment Mode | Primary Referral | Secondary Referral |
|---|---|---|---|
| 1) Impulsive | RT, CT, BM, BC<br>NOTE: | Outpatient Drug and Alcohol Center. Persons who "Potentiate" behavior with chemicals, may have a more serious problem than those who don't. | Law Enforcement or an Inpatient Facility. |
| 2) Depressed withdrawn | BC, IT, AT, SM, RT, FT, BM | Outpatient Drug and Alcohol Center. | Mental Health Center or Inpatient Facility. |
| 3) Traumatic withdrawn | CI, CT, ST | Direct crisis intervention by the crisis worker is often appropriate. | Home, Halfway House, Welfare, or Employment Services. |
| 4) Historical withdrawn | CI, IT, RA, LIT | Outpatient Mental Health Center. | Inpatient Mental Health Facility. |
| 5) Social | CI, CT, ST, RT, BM | Direct crisis intervention by the crisis worker is often appropriate. | Alcoholism and Drug Outpatient Center, or other secondary sources mentioned in (3). |

***TREATMENT MODE KEY:**

RT — Role Training
BM — Behavior Modification
BC — Brief Counseling
FT — Family Therapy
CT — Confrontation Therapy
CI — Crisis Intervention
LIT — Long-term Inpatient Therapy
ST — Supportive Therapy
IT — Insight Therapy
AT — Assertiveness Training
SM — Stress Management
RA — Recreational Activities

**Note:** If hallucinatory behavior is also present, the crisis worker should establish which kind it is and combine treatment and referral comments.

in the immediate crisis and resolve part of the problem. If the person-in-crisis is alone and alienated, then the establishment of rapport is, in itself, a way of reducing his intense feelings regarding circumstances. The addition of a new trustable worthy friend can do wonders. In addition, you as a crisis worker can now work to effect the person-in-crisis' way of approaching the problem as well as to suggest alternate actions he can take which may alleviate the stress. There are also times when people or agencies in the community need to be contacted immediately and recruited to act on behalf of the person-in-crisis. The crisis worker may have to make such calls or visits when it is appropriate. Often it is also necessary to confront the person with very short term goals, in order to obtain a commitment from him in the midst of crisis. Generally then, the treatment mode would be supportive and confrontive, but would involve the crisis worker directly. Actual referrals would be to supportive community agencies which provide jobs, training, housing, money, etc.

The last kind of withdrawn behavior refers to long-standing withdrawal as a part of the person-in-crisis' personality. More and more of these persons are being seen in crisis because of the community mental health movement. As more persons are discharged from long-term inpatient settings back into the community, more of them become involved in crisis. It should be mentioned that although more of them are being seen, many of them prefer ideation and unresponsiveness to drugs and alcohol. Unpleasant states of mind are avoided by lack of environmental excitation coupled with highly personal but fulfilling dreamlike states. If withdrawal behavior like this is identified in crisis, it would be more prudent to explore the possibility of hallucinatory behavior based on underlying mental problems, then to pursue symptomatic drug and alcohol problems. However, care should be taken to make sure the problem is truly long-standing.

In addition, treatment in a mental health setting which focuses on withdrawal (and perhaps hallucinations) may be in order. If the person-in-crisis is unable to continue functioning in the community a referral to an inpatient unit may be necessary. If an alcohol or drug problem is present and the withdrawn behavior occurs independent of chemical abuse, the chemical problem is

secondary to the underlying mental problem. If withdrawn behavior occurs with hallucinations and chemical abuse, and the hallucinations occur only in conjunction with the chemical abuse, then we have hallucinatory behavior associated with chemical abuse (see Appendix D) which is discussed in the hallucinations section. Referrals, in this case, probably should be made first to an inpatient psychiatric unit, followed by referral to an inpatient alcohol and/or drug unit (see table 2). It should be remembered that historical withdrawn behavior is often serious business, particularly if hallucinations are evident. Even if the person-in-crisis is in an intoxicated state, the primary problem probably is the mental problem. If hallucinations are not present but the withdrawn behavior is, care should be taken to compare the available historical information with present information to see if the withdrawal is a result of the present crisis, recent events, or is a long-standing problem.

In many ways a person-in-crisis who exhibits inappropriate or appropriate social behavior is like the traumatic withdrawn behavior type. However, a prime difference is that withdrawal behavior in the crisis situation is not present. In addition, the philosophies of the withdrawn and social behavior types are different. The social type is a part of the fabric of society. Other than that, there is a general lack of serious underlying mental problems, and both types are able to cope in crisis, although the intensity of the crisis itself may force him to exhibit behavior which reflects stress. It should be noted that only occasionally will this type utilize chemicals to alter his mood.

The appropriate behavior type never abuses chemicals continuously unless the rewards (ie: status, recognition, etc.) that society usually bestows on such persons are withheld or diminished so as to cause an unpleasant state of affairs for him. In order to differentiate between appropriate and inappropriate social behavior it is necessary to ascertain whether the person-in-crisis has historically exhibited appropriate or inappropriate (maladaptive) behavior. That is, although both person's want to conform and believe in rules and regulations, one generally succeeds and the other does not. If chemical abuse is a problem, behavior modification is a real possibility for such person's since they seek worldly rewards in real life regularly. Further, usually

no underlying pathology is present which would lend itself to dysfunctional behavior under stress. Once again, we are dealing with people-in-crisis who, if the crisis were resolved would function relatively well. In such situations, the crisis worker has the chance to provide direct action which can alleviate the problem. Face-to-face confrontations by the crisis worker are encouraged after rapport and information gathering has occurred. In that way, change can be effected through the establishment of short-term goals and some commitment to them by the person-in-crisis and the crisis worker. I would like to add that although no underlying problems are evident, and only few chemical abuse problems arise, these persons are a very good prospect for success, using behavior modification and/or role training techniques in short-term treatment. So, unlike the traumatic withdrawn behavior type, drug and alcohol problems can be dealt with effectively through referrals to alcoholism and drug out-patient centers, if the crisis cannot be resolved effectively by the crisis worker (see table 2).

Although all of the previously mentioned behaviors may be associated with hallucinations, some are more likely than others to illicit them. For instance, it has already been mentioned that the historically withdrawn behavior type is most likely to accompany hallucinatory behavior. But the ingestion of chemicals can also result in hallucinations. In addition, some medical or organic problems can produce hallucinatory behavior. The difference between all of these kinds of hallucinatory behavior have already been discussed in the preceding section. Suffice it to say that I have chosen to treat hallucinations as a special behavior category where it occurs in crisis. Furthermore, it is important to differentiate chemically induced hallucinatory behavior from other kinds of hallucinations (see Appendix D). It is also important to mention that hallucinations are not commonly seen in drug and alcohol crisis. However, if it occurs, it is likely that you have a serious problem that could involve referral to an inpatient psychiatric unit if the primary problem is emotional. On the other hand, a referral to an inpatient medical unit with a drug and alcoholism component is called for if the ingestion of chemicals is the cause of the hallucinatory behavior. In the first case, the treatment made may

have to be long-term involving well-qualified professionals, while in the second case behavior modification or action approaches such as role training and/or the various confrontation therapies can be very effective if delivered by experienced and competent counselors or psychotherapists.

I would like to mention in closing that sometimes no amount of crisis work with a person-in-crisis can effect problem resolution. In such cases, other community agencies or individuals should be identified which can alleviate the problem in some way. In other words, the crisis worker usually looks at the person-in-crisis with the idea of alleviating some of his pain by resolving some of the conflict between him and society. Sometimes it is discovered that he has a problem of his own. At other times it's a problem created by the world around him. It is clear that in all cases we assume a fair and just society . . . The one exception seems to be the case of someone in crisis who exhibits appropriate social behavior. In that case, I am talking about one who is in conformance with society's sanctions, but does not receive his just reward. As a result of such injustice, a person sometimes may choose to abuse chemicals in a frantic attempt to alter the unpleasant feelings acquired from not getting what is rightfully his. Carrying that a step further, suppose some elements of society are not just withholding rewards, but are outright malicious. In that case, the wrong people may be rewarded and the right people punished. Anyone seen in crisis could be stressed by unjust forces in the environment, regardless of their social competence or internal problems. The problem is with the environment and has little or nothing to do with the person-in-crisis except that he is the scapegoat. Certainly then, this is not a behavior type, but is an alternative to seeing the problem as totally the property of the person-in-crisis. If during information gathering, it is documented that some business, family, politician, local government, state agency, or local service provider is over-stepping its bounds, you should obtain additional information through consumer advocacy groups and some other appropriate agency. You may also need to commit yourself to protecting the person-in-crisis if an immediate threat exists, until more is known about the source of the problem. The important thing is that in each crisis the possibility exists that crisis resolu-

tion cannot occur before an intervention is made with the community.

## CHAPTER 6

# INTERPRETATION

Up to this point, discussion has focused on what the crisis worker should do and what model he should utilize. This section deals with how one can apply such concepts in crisis. In order to do that, the one-act play in Appendix A will be treated as a real life crisis and our model will be applied.

To begin, let us assume that you are an experienced and trained alcohol and drug crisis worker. You should already have read the play in Appendix A thoroughly. Given all that, you are now ready to begin the application of our chemical crisis model to the existential interplay of the play's cast of characters.

In any crisis situation there is an information-gathering phase which precedes the use of a model. In this phase, rapport is established, but action cannot yet be taken. Decision-making occurs during the planning states when enough information is available to make a responsible decision. In this case, decisions will be made using the model presented in this book. The crisis worker in the play spent considerable time gathering information about the person-in-crisis before drawing any conclusions. In fact, the play opened with his listening to talk about

the person-in-crisis. He found that he is a local jeweler who has been in jail for D.W.I., assault, and public intoxication. In addition, he has O.D.'d on drugs at the local hospital. He also finds that he's made a shambles of his present apartment and has been shouting and screaming. He discovers that he's also a hometown boy, that his dad died a few years back, and that his Mother is alive and lives across town. Generally this is a mixture of historical and present crisis (see page 78) information. For the most part, information-gathering continues as the officer and the crisis worker enter the apartment. The first bit of personal information is volunteered as the person-in-crisis' moans belie his depression. It is learned from the mother that Harold may have identified with his Father, that he has been divorced for sometime, that he still sees them regularly, and that she has remarried and has two children by him. It is also learned that they were married about five years in the sixties, that it was a constant battle for her, and that he would get drunk and land in jail for resisting arrest. Further, Harold apparently went partying and raised hell from the time of the divorce till the present. It was also suggested that he really cares, but acts like he doesn't give a damn. There was also considerable anger voiced toward him by those closest to him, because of all the pain and trouble he has caused. At this point it is apparent, that personal information (see Page 81) about Harold is being discussed. Still more information was offered by Harold's Mother as she described him as drunk and raising hell in his apartment. Presumably he visited his re-married ex-wife and two kids earlier. She went on to say that he called her from his apartment earlier in the evening, but was so drunk and crude that she hung up on him. It should be mentioned that it was obvious that Harold was drunk throughout all this, and was intermittently angry. At times that anger seemed directed at male authority (the policeman) and particularly toward women.

When the crisis worker finally gets the chance to talk with Harold, he finds it very difficult to establish rapport because of his drunkenness. As a result, little information was obtained directly from him. But rapport was established with his mother who volunteered much of the information. Still, Harold does say he's been home most of the time. He also suggests that he may

not be telling the truth by being evasive and making a joke referring to "booze" as his friend. It was also inferred from his intoxicated state that he had consumed a lot of some chemical, probably mostly alcohol, quite recently. All this seems like personal and present crisis information. When the crisis worker once again returns to converse with Harold's mother, he learned that the phone call to her took place at four or five in the afternoon. She also says she went over to his apartment later, but he was swearing and ripping everything up. From there on, she regresses, at the crisis worker's request, by giving more historical material about her son's past. It is established that he has had ongoing problems interacting with females all of his life, presumably because he could not express his hostile feelings to them in any appropriate way. Further, it was suggested that he was able to vent the previously mentioned hostility in the presence of males, but seems to experience loss of control, with the whole experience becoming cathartic as well as socially inappropriate. His mother goes on to say that Harold has always been overly sensitive to any kind of criticism and has a tendency to take things too personally at times. She further states that he may have been mad at his ex-wife this afternoon, since he came home mad and he apparently had just seen her. It was implied that what had made him mad may have been minor or unimportant, since he has trouble taking criticism. On the other hand, his mother says it might be justified anger, since she isn't happy about him seeing the children so much lately and may have finally told him off. From that point on, decisions begin to be made by the crisis worker using the chemical crisis model. There are, however, a couple of instances of additional information which have a good deal to do with decision-making. For instance, after Harold leaves to go to the hospital, the conversation between the crisis worker and Mrs. Sebring continues. It is determined that Harold has become more withdrawn and less interested in people and things in recent years. She mentions that these changes are related to the death of his father and his divorce. It is implied that he still feels strongly about the loss of both people after all these years. She also mentions his current financial problems which are related to recent mismanagement of the store. Mrs. Sebring continues by admitting that he occa-

sionally talks about "making them feel sorry when he's gone" . . . the implication being that such statements are somehow connected to notions about suicide. She also said that Harold has felt "caged" most of his life and disliked institutions, discipline, and regulations. She added that he was a "doer" not a "thinker." She further emphasized that these ideas were mostly speculation.

More information was added toward the end of the play when the woman from across the hall entered. She volunteered that Harold kept saying over and over that "he killed him" as he tore his apartment apart. Further, she also said that the name "Hank" was mentioned.

Now that all the necessary information has been gathered, it is possible to begin looking to our model for a crisis plan which includes action. The first step in such a process is described in the first question at the top of the page of Charts 1 through 3. The question posed, addresses the problem of whether the problems described by the crisis can best be resolved by working with the person-in-crisis or by working with other individuals or agencies within the immediate community. If the crisis problem is thought to be "owned" by the person-in-crisis, then one proceeds to the next question down on the flow chart. If not, one must identify who else "owns" the problem, while supporting the person-in-crisis. In this case, it is clear at the beginning that Harold "owns" the crisis problem, so we now may try to deal with the second question in Tables one (1) through three (3) which asks which of the three behavioral types is presented.

Early in the play when the officer and the crisis worker enter the apartment, Harold's moan belies the depression which underlie his behavior. Apparently, his impulsiveness is an attempt to alter his underlying feelings (ie: depression) as described in the crisis alternatives model. The ensuing drunken behavior (which follows his moan) suggests that he is attempting to further potentiate his impulsive behavior with alcohol in a monumental attempt to alter his depression. His show of anger toward the policeman suggests that his attempt to alter his depression is successful since it appears that it has turned to anger. Later on in the play there are other instances where Harold displays impulsive behavior while intoxicated. Infor-

mation regarding the past also reinforces the idea that Harold has a long-standing problem of impulsiveness, together with drunkenness. Such behavior strongly suggests that Harold is exhibiting impulsive behavior presently, and has produced it consistently in the past.

The next question on Chart 1 has already been answered. It has already been established that Harold potentiates chemicals (alcohol) and behavior (impulsiveness). From the series of decisions, it can be theorized that Harold has intense underlying feelings (ie: depression) which presents a problem for him. He also may have a problem expressing his anger in socially appropriate ways (see Chart 1).

At this point in the play (page 85) the crisis worker moves back over to the stuporous person-in-crisis to perform a couple of simple coordination tests. His conclusion is that he may experience D.T.'s in the next few hours. The crisis worker then performs his first immediate action as he makes the decision to refer him to the nearest local hospital for observation and drying-out (See table 2, page 61). Such a referral is called for since there appears to be a high risk that hallucinations (D.T.'s) will develop (see Chart 4, page 52). Such hallucinations call for emergency medical services first, followed by a referral to the nearest appropriate alcohol and drug center. If the crisis worker had reason to believe that hallucinatory behavior was not the result of ingested chemicals (in this case alcohol), then a psychiatric problem and intense underlying emotions should be suspected. It should also be mentioned that it is also known that Harold has a mild case of diabetes. This could be another reason for making the initial referral to a medical facility. As part of the initial action plan, the officer is asked to transport Harold, but is given specific instructions on how to avoid his going into D.T.'s in route. In this case, the action is accomplished through referrals to other agencies or individuals.

After Harold leaves with the officer, Mrs. Sebring describes her son as rather withdrawn and disinterested lately. She even implied that his grief may go as far as thoughts of suicide. There also was some discussion of what Harold believes. She said he disliked institutions, discipline, regulations, religion, and was a "doer." It does seem clear now that Harold's belief system fits

the philosophy of the impulsive behavioral type. However, his more recent withdrawn behavior suggests it's getting harder to respond impulsively in the face of the punishment and rejection that society hands out. In which case he is defenseless against the onset of depression, since he no longer has impulsive behavior to alter it. Probably the only thing left is more of the mood altering effects of chemicals.

Although the crisis alternatives model has provided some guidelines regarding Harold's problems and has suggested referrals, his more immediate problems have not been solved. Although his present behavior is impulsive, he has been withdrawn recently. This suggests something triggered his present behavior. When the next door neighbor says that he said that "he killed him," the idea arises that something else happened earlier that we do not know about. Passing mention that she heard him refer to a man named "[redacted]ank," adds to the mystery. When the policeman at the hospital calls back to say that a man named "[redacted]ank" was drinking earlier with Harold; the mystery is over. Harold was so drunk that the two of them fought. In fact, Harold was so drunk he thought he had killed him. In drunken grief he had come back and tore up his apartment. The immediate crisis can now be resolved by taking the final needed action of informing the officer and hospital staff about what actually happened. As soon as he is able, Harold too will know that "[redacted]ank" is alive and well. So all's well that ends well, except the treatment process may just be beginning.

I would like to mention in closing that a number of other important inferences can be made regarding Harold's personality from the script in Appendix A. For instance, there were several places where it looked like he had problems relating to women, poor self image, and perhaps had a tendency to lose control in the presence of male authority. Such information can easily be included in the crisis plan together with the inferences obtained through the use of the chemical crisis model.

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# APPENDIX A

# THE CRISIS
## A ONE-ACT PLAY

## BY
## FLOYD SOURS

---

### CAST OF CHARACTERS

Jay Morris . . . . . The Drug and Alcohol Crisis Worker
Officer Mallory . . . . . The Policeman
Harold Sebring . . . . . The Alcoholic
Mrs. Mildred Sebring . . . . . The Alcoholics Mother
Alice Bellows . . . . . The Neighbor

NOTE: This play is intended for mature audiences. The contents and language portray in a realistic manner the events which take place.

**SCENE 1:**

*The curtain is closed and the stage lights are low to create the illusion that it is night. At the outset two voices are heard off stage right. The voices are just audible accompanied by the sound of steps, so as to sound like two men walking, talking, and moving slowly in front of the audience across the stage. The voices belong to Don Mallory, a local policeman, and Jay Morris, an Alcohol and Drug Crisis Worker from a local Center.*

**Officer Mallory:** (Barely audible voice coming from stage right): Look, I'm really sorry to get you out of bed this late, but I've tried just about everything I know. You know, I could throw the son-of-a-bitch in jail . . .I mean, he actually

deserves it. But I don't really know what the damn problem is I mean . . . well . . . goddammit Jay . . . everyone in town knows him because of his business. You know, he's had a lot of run-ins with us before . . . in fact he's been thrown in jail plenty of times already. It just doesn't seem to help.

**Jay Morris:** (voice more audible): Uh . . . what doesn't seem to help Don?

**Officer Mallory:** Why throwing him in jail. Shit . . . he seems to enjoy it.

**Jay Morris:** What do you usually pick him up for anyway?

**Officer Mallory:** Uh . . . D.W.I. mostly . . . but he's also been picked up for assault and public intoxication. (pause) Jesus . . . I can remember that one all right. Orville Tubbs and I were called out because of wild goings-on at his house. It was one of the wildest parties I can remember, and he was in his glory with all his crazy friends. He was really drunk. When Orville tried to talk to him, he just took a swing at him. It took both of us to overcome him and take him in. Then later, he went nuts in his cell and we had to put him in the State Hospital for awhile. The fact is, he's been in and out of several hospitals.

**Jay Morris:** Oh! which hospitals?

**Officer Mallory:** (both voices are now fully audible, and both men enter front stage right with spot on them walking and stopping slowly): I don't know for sure, but it's well known around town that he also does dope. Ol' Doc Sandrich tells the story of how he came into City Hospital O.D.'d on somethin'. Wouldn't tell nobody what he took. The hospital staff were scared to death he'd die before their eyes, but he pulled through. They found a bunch of stuff on him that night . . . some prescription; some not. But they didn't know which he took. But that didn't teach him . . . no sir . . . Christ, nothing does.

**Jay Morris:** (stopping center stage with center spot): Well, what'd he do this time?

**Officer Mallory:** Oh . . . he's supposedly made a shambles of his new apartment and he's been shouting and screaming obscenities for all to hear. Several neighbors called the station. You know, I've been through this before with him, so I thought I'd bring you along this time.

**Jay Morris:** (nervous laugh): Well . . . I hope I'm able to help Don. . . You know, I do have a few years experience working with this kind of thing.

**Officer Mallory:** Yeh, I know . . . but these kinds of problems are so difficult.

**Jay Morris:** (changing the subject): What do you know about what's-his-name's background?

**Officer Mallory:** (walking off stage left talking): Uh . . . he's a hometown boy . . . by the way, his name's Harold Sebring . . . and both parents have been around here for most of their lives too. His dad died a few years ago of a heart attack, and his mother lives across town in the Wilmet Apartments. She's in her late sixties. Both were good people and never got into trouble. Although I do vaguely remember some rumors that Harold's dad used to occasionally get into weekend bar brawls when he was just starting out with his jewelry store.

**Jay Morris:** Hey Look! The door's open . . . (pause) do you hear something? (A low moan just barely can be heard).

**SCENE 2:** *The curtain opens to the inside of the apartment. It is well furnished. It consists of a living room, with a kitchenette attached but out of sight. There are two doors: one leading to a bedroom behind the living room, and another to the far left which is the entrance-way (It is slightly ajar). There are several empty whiskey bottles and bottles of pills strewn about the room. The room is a mess with everything disordered. There are some overturned end tables, desk drawers are all pulled out, and a suitcase is opened upside down on the floor with its contents lying about. Only a picture of a woman and two children is upright sitting on a small table next to a chair on the left side of the room. In the middle of the living room is a middle aged male in his bathrobe slumped in a chair with his head in his hands. Ever so often a low pitched cry can be heard, conveying the message of intense grief. As the curtain rises, one solitary spotlight focuses on the man in the chair. However, the other stage lights must light the stage enough to follow the action of other persons in the room. Voices can be heard from stage left as Officer Mallory and Jay Morris enter . . .*

**Officer Mallory:** Hello! Is anyone here? (Whispering) Hey Jay, try to find a light switch, I can't see nothing.

**Jay Morris:** Here it is (lights on) . . . (Both Jay and Officer Mallory look around the room; suddenly they see the figure slumped in chair) Hey look! . . .

**Harold Sebring:** (man in chair) Uh! . . . Wha . . . What's . . . Whoszat! (stands up wobbling; is obviously intoxicated . . . starts to move toward them, but can hardly stand). Hey you . . . whatcha doing . . . whatcha doing here! (stumbles and

shouts) Hey Mom . . . help, there's . . . people coming in here . . . (falls down) . . .

**Officer Mallory:** (after moving over to Harold, he picks him gently up off the floor) Harold . . . Harold . . . it's me, remember me? . . . Jim Mallory? . . . .

**Harold:** Uh . . . Uh . . . (begins to exhibit a growing anger, and suddenly seems more beligerant) listen Mallory, I don't care who you are . . . I don't like you or anything about you. Hey Mom . . . get out here . . . quick . . . (Stumbles a bit . . . but his anger seems to shore him up some, so he no longer appears quite so drunk).

**Jay Morris:** (after standing back and to the side of Officer Mallory, he moves in front facing Harold). Harold . . . my name is Jay Morris and I'm . . .

**Harold:** (moves back and away from both people, cutting Jay off in mid-sentence): Hey Mom . . . get out here . . .

**Mildred Sebring:** (enter a woman in her sixties from the bedroom in back): Harold . . . what's going on here - - - (slows to a surprised stop, after bursting forth quickly on the scene). Oh! — Who are you?

**Officer Mallory:** Jim Mallory's the name Maam; the neighbors called the station awhile back saying there was a general uproar here. Me and Mr. Morris from the Crisis Center came up here to see what's going on. We just came in when we saw the door open. Thought someone might be hurt. (Harold continues to appear unable to stand. Jay tries to lead him back to his chair . . . as Harold gives Jay a rough time).

**Mildred Sebring:** (she becomes visibly shaken as she talks): Oh yes, I was one of them who phoned: Harold was in the room with me at the time, and I didn't dare say who I was or who I was calling for fear he'd hit me. It's OK now though . . .he's much too tipsy to do anything now.

**Officer Mallory:** Well Maam, I know this is difficult, but Mr. Morris and myself (motions Jay to him) would like to ask you a few questions about what happened. (Jay leaves Harold in the chair, and walks over to Mallory and Mrs. Sebring).

**Mildred Sebring:** (with handkerchief to eyes): Surely, I'd be more than happy to help you if I can.

**Officer Mallory:** Well, how did all this start?

**Mildred Sebring:** To tell the truth, I just don't know . . . Harold was just fine yesterday, and now this. I just don't understand. I mean I've always tried to be a good mother, but he's so much like his father.

**Jay Morris:** Excuse me Mrs. Sebring, but what happened tonight

that changed things?

**Mildred Sebring:** Well, I really don't know . . . earlier this evening he called me at home, and he was drunk then. He did mention that he had visited Helen and the kids earlier, but he does every once in awhile. He was crude and foul to me on the phone, so I hung up on him. I just can't stand it, when he acts like that.

**Jay Morris:** (to Mildred) Who are Helen and the kids? (Harold slowly gets out of his chair and, drunk, moves toward Mildred and Jay).

**Mildred Sebring:** Helen? Oh, that's Harold's ex-wife . . . Harold was married some years ago — she's re-married now, but Harold still sees her and the kids regularly. He never did deserve them . . .

**Harold Sebring:** (stumbling into the conversation): Wha . . . what's going on here?

**Mildred Sebring:** (continuing on . . . ignoring Harold): Yes, they were married back in the sixties for five years or so. But it was a constant battle. Harold would get drunk and come home and raise hell . . . or abuse the children. God! I don't know how she put up with it. He always had some hair-brained scheme to make money . . . that never worked . . . and he was always dragging worthless junk home with him. Everything from empty pony kegs of beer to damaged old furniture. She had the patience of a saint . . . But, it finally came to an end when he got drunk one night and filled his car with gas from a local gas station and drove off without paying. When he was picked up, he resisted arrest, and was put in jail. It was the last straw for Helen . . .

**Harold Sebring:** (getting visible, agitated and aggressive) Fuck you! All of you . . . you son-of-bitches . . . have no right coming to my house! (falls down)

**Mildred Sebring:** Now Harold . . . stop it . . . these folks are here to help (she guides him back to his chair). . . now be a good boy and rest. (sets him down in chair) (Officer Mallory comes over to stand behind him as he slumps in the chair). Now, lets see where was I? Oh yes, well Helen left . . . that was it . . . and Harold went back to partying and raising hell.

**Jay Morris:** Mrs. Sebring . . . do you think Harold had any feelings for his wife and kids?

**Mildred Sebring:** Well yes, or he wouldn't have spent so much time with them over the years. But Harold always was one to spoil a good thing, and anyway . . . as far as I know he doesn't act like he cares for much of anybody.

**Jay Morris:** That's just it . . . do you suppose it is just that . . . an

act . . . but really inside, Harold has feelings like the rest of us.

**Mildred Sebring:** (looking nervously over at Harold to make sure he didn't hear) Uh . . . sure . . . Harold feels like the rest of us . . .I mean I didn't mean to suggest (whispering now. . .) that he had no feelings . . . It's just that all his life he's been in trouble and has caused a lot of pain to all of us who are close to him. Sometimes I get so mad at him I could just kill him. (Harold staggers up with an ear to the conversation as if he heard something that interest him) Why he . . .

**Harold Sebring:** (butting into the conversation) You old bitch . . . you don't know anything . . . (becoming beligerant while seeming less intoxicated). All my life you've been telling me what I shouldn't do, never what I should do . . . you and Helen . . . both of you iron goddesses with your righteous uncaring ways (Mildred begins to look frightened) . . . No . . . No . . . (taunting) No . . . always No . . .

**Mildred Sebring:** (crying now) Oh no Harold . . . not now . . . I've had such a hard day. Please . . .

**Jay Morris:** (intervenes and grabs Harold gently . . . steering him back to his chair). Come on Harold! . . . That's it! . . .don't worry.

**Harold Sebring:** (sitting in his chair; seems more sober now; but suddenly tired and sad) Oh God! I'm so tired (mutters).

**Jay Morris:** Harold, I don't mean to change the subject, but do you remember what you were doing earlier this evening?

**Harold Sebring:** (slightly startled by the question) Uh . . . yes. I've been home most of the time . . . with my friends (points to fifth laying on the floor and smiles).

**Jay Morris:** How many of those do you have around here?

**Harold Sebring:** A lot (proudly).

**Jay Morris:** How much is a lot?

**Harold Sebring:** Oh . . . there was a whole case this morning in the kitchen. (Officer Mallory, overhearing this, now moves into the kitchen out of sight to count how many are left.)

**Jay Morris:** Do you have any other friends like that?

**Harold Sebring:** (Suddenly getting suspicious and offended) Hey . . . what is this the third degree? Do you think I'm stupid or something? I know what the hell's going on, and I'm not going to say another thing. Hey, who are you anyway?

**Jay Morris:** Oh . . . hey I'm sorry . . .I'm Jay Morris from the Drug and Alcohol Center . . . I just come over with Officer Mallory to see if I could help in some way.

**Harold Sebring:** Hey, a shrink . . . Hey look Mom, they sent a shrink this time . . .HA! Well, you can't help me -- no sir --.

**Jay Morris:** Say Harold . . . look I can't help notice the room and all the booze; are you sure you can't recall what happened?

**Harold Sebring:** (Shouting) Happened! (calming down a little) I mean . . . (holds his head) . . . well . . . (suddenly insight) Mmm . . . I need a drink. (Runs around room looking for bottle).

**Jay Morris:** (walking back over to Mrs. Sebring) Mrs. Sebring, is there anyone around here who knows what happened?

**Mildred Sebring:** All I know is that after I hung up the phone on Harold I began to worry; that was about four or five this afternoon. Later on, I did go over to see how he was . . . well, that was a mistake.

**Jay Morris:** A mistake?

**Mildred Sebring:** Yes . . . well when I got there Harold was real crazy. I mean he was ripping up his own apartment, and swearing at the top of his lungs. You should have heard the vile words coming out of his mouth . . . why it was disgusting.

**Jay Morris:** Yes . . . Well . . . I can imagine. From what I can gather, he breaks out into this kind of foul song quite often -- right?

**Mildred Sebring:** (embarrassed) Oh . . . not that often, but you're right, he's been rude and offensive all his life.

**Jay Morris:** (more intensely; moving closer) Now think . . .it could be important . . . can you remember another time when he was younger when he lost control like he did tonight?

**Mildred Sebring:** Oh dear! I'm not at all sure I remember. I just don't know . . . (pause) Well . . . I do remember once a long time ago . . . I believe Harold was in high school . . . Uh, he just attacked this boy at the Corral . . . that's a drive-in where all the kids went after the games. Gosh, the police called Joe and me. Uh, my husband was alive then . . . and said he was just out of control and for us to get right down there. Well, we went . . . and sure enough there he was letting go with the vile words like they wasn't his to say. Why it was like there was a devil in him.

**Jay Morris:** I see . . . is it possible to remember some of the things which happened to Harold just a few days before that incident?

**Mildred Sebring:** Well let's see . . . that was a Saturday night I believe and it was fall . . . yea, fall because there was a football game the night before . . . and a dance . . . yes, the homecoming dance. It was that girl . . . the one he used to date . . . (thinking) . . . I don't remember her very clearly, but he took her . . . yes he took her to that dance . . . the

homecoming dance. She was such a nice girl.

**Jay Morris:** What happened Mrs. Sebring?

**Mildred Sebring:** Why he took her to the dance . . . and then he took her home. What else?

**Jay Morris:** Oh yes! But what do you suppose got him so vile and mad the next night.

**Mildred Sebring:** Well I just don't know . . . I mean he brought her home and all.

**Jay Morris:** Oh, I see, he had a date with her the next night too.

**Mildred Sebring:** No! I mean he brought her home after the Homecoming dance.

**Jay Morris:** (a bit frustrated and disillusioned) Oh! well. Then I guess she had nothing to do with him getting mad the next night.

**Mildred Sebring:** Well, I wouldn't exactly say that either. Harold always had trouble with his girls. It's just that I really don't . . . (pause) . . . wait a minute, like I was telling you, Joe and I went down to the jail after Harold. He was really raisin' cain when we got there. Anyway, Joe really gave it to him. He actually knocked Harold down, right there in the county jail. Well, it calmed him down, and then Joe talked with him awhile. On the way back in the car, I remember Joe said something about how it was her fault, cause they had an argument the night before. Harold probably got mad and left, cause he won't hit women. I mean, we brought him up never to hit women. I suppose he finally got in trouble the next night at the drive-in; and you can bet he was drinkin' too.

**Officer Mallory:** (enters room from attached kitchen — everyone turns to look) Good God, you oughta see the kitchen. It looks like he's drank a couple of fifths and then played with the rest, stacking them up like he was building a wall. It's a wonder they haven't come crashing down. There's also more prescription medication laying all over the floor. Looks like Librium. Boy! (walks right up to Jay and Mrs. Sebring and stops) Oh! go right on, I didn't mean to interrupt.

**Jay Morris:** (looking back to Mrs. Sebring) You were saying?

**Mildred Sebring:** Oh, that was about it anyway . . . except that Harold's life has sort of been a replay of that sort of thing. He gets a girl or wife, they argue, he gets mad and leaves, he gets drunk and gets into trouble.

**Jay Morris:** You said he gets a girl or wife; before that, did he ever get mad at you?

**Mildred Sebring:** Land Sakes yes! He was always in trouble as a child. He

was just unmanageable. Why, only his father could handle him. I tried but he scared me to death when he'd get angry. I just couldn't discipline him.

**Jay Morris:** Well . . . What sorts of things usually trigger Harold off . . .I mean what happens that makes him so mad?

**Mildred Sebring:** Oh I don't know . . . almost any kind of criticism. He takes everything so personally at times.

**Jay Morris:** Well what about earlier this evening Mrs. Sebring? Did he get that way then?

**Mildred Sebring:** (slightly startled to be back in the present) Oh! Well, when I called early in the evening he was madder than hops about something . . .

**Officer Mallory:** (looking around quickly toward Harold who is still stumbling around drunk . . . he has knocked over an end table partially) Hey Harold . . . (rushes over to grab him) . . . quit breaking things . . . (leads him back over to the chair and sits him down).

**Mildred Sebring:** Anyway, he may have been mad at Helen for something. It didn't really have to be anything big or important, when he gets mad he gets mad. (pause) . . . You know, they've been seeing more of each other again lately, cause he's wanted to see the kids more. I mean she really isn't happy about his seeing the kids now at all. She might have gotten fed up and told him finally where to go . . .

**Jay Morris:** What makes you think that?

**Mildred Sebring:** Oh, I talk regularly with Helen on the phone. Although I haven't talked to her for a few days now.

**Jay Morris:** Do you think you could give her a call now to see if anything happened?

**Mildred Sebring:** Well it is late, but I guess I could. Sure! (walks over to the phone and dials).

**Jay Morris:** (moves over to Officer Mallory and Harold. Kneels down to talk with Harold) Harold! (shakes him gently) can you hold your hands out in front of you like this? (Jay holds both hands out in front of him. Harold tries, but his hands tremble and he can't hold them level together. Jay also looks at his pupils) Harold, how long have you been drinking?

**Harold Sebring:** Uh . . . not long . . . Uh . . . just a little while. (Slumps down in a half stupor).

**Mildred Sebring:** (hangs up phone, after talking in low tones and walks over to Jay. She taps him on the shoulder, and motions him away from Harold to talk. Both move away to stage left to talk privately) Well, I was partly right. She says he's been drunk lately when he brings the kids back from

visits, and he's threatened her. This afternoon he was particularly vile, and she kicked him out. She told him not to come back until he was sober. He's probably been loaded for days.

**Jay Morris:** Hmm! You know it looks like we've really got a case here, it's my bet that he'll go into D.T.'s in the next few hours unless he gets some more booze. Tell me, what kind of health is he in?

**Mildred Sebring:** Oh, he's in pretty good health. He's had a few problems on and off with his diabetes, but mostly he's been healthy.

**Jay Morris:** Does he or has he ever taken insulin?

**Mildred Sebring:** No.

**Jay Morris:** (talks across the room to Officer Mallory) Hey Don, would you get on the phone and call the hospital? It looks like we've got an emergency admission . . . and tell them his family doctor's name . . . OK?

**Officer Mallory:** Yeh . . . OK. (walks to phone and picks it up to dial). (talks in low inaudible tones).

**Jay Morris:** (continues talking with Mrs. Sebring) Umm . . . Mildred, how does Harold spend most of his time these days?

**Mildred Sebring:** (thoughtfully) Oh, I guess he spends most of his time at home here, and divides the rest between the jewelry store, Mauries, and those floozies he sees. Uh, Mauries is a local bar that Harold has frequented for years. In fact, its owned by an old friend of Harold's. Or I should say he used to be a friend. I mean George gave up on Harold a number of years ago when they both took off together on a lark for a couple of weeks. George said he just couldn't keep up with Harold anymore, but Harold still goes into Mauries on occasion.

**Officer Mallory:** (holding hand over phone) Hey Jay, they say to get him down to the emergency room. Should I take him there, or do you think I should call an ambulance?

**Jay Morris:** Well . . . why don't you take him, but give him a couple of stiff swigs of booze before you leave. That way he'll be quiet on the way, and you'll avoid his going into D.T.'s in your car.

**Officer Mallory:** OK! (Mallory moves over towards Harold and gives him several swigs of booze).

**Jay Morris:** You were saying?

**Mildred Sebring:** Well Harold also spent a bit of time with a couple of young divorcees in town, but I think he only went over there when he needed to . . . if you know what I mean. Actually, he hasn't had any close friends for a number of years. You know, now that I think of it, that group down at

Mauries that used to run together and throw wild parties all the time are all mostly remarried or gone now. I guess Harold doesn't even have drinking friends anymore. You know, I guess that's why he stays at home more now. (Officer Mallory gets Harold up on his feet and helps him across the room and out the door. When he gets to the door he stops, and turns back to Jay).

**Officer Mallory:** I'll phone back when I get to the emergency room. We're to meet Doc Sandrich there.

**Jay Morris:** OK. (Officer Mallory leaves with Harold, closing the door behind him). Go on Mildred.

**Mildred Sebring:** You know . . . now that I think about it . . . Harold just isn't quite the same old guy he used to be. I mean he doesn't go out as much, and he talks a lot about the past. You know he just looks kind of preoccupied when people talk to him too . . . almost as if he's not interested. Of course that's what it seems like to me, he's another person even today when he starts drinking.

**Jay Morris:** (both turn and look at the door Harold just left thru) I know. (pause) Mildred, has Harold ever attempted to take his own life?

**Mildred Sebring:** Not that I know of . . . but when he's drunk he sometimes talks about how we'll be sorry someday when he's gone . . .

**Jay Morris:** Uh, from what you've told me, some dramatic changes have taken place in recent years with Harold. What do you suppose caused them?

**Mildred Sebring:** Oh . . . a number of things . . . I mean Harold never shows his feelings much, but I know it was awful for him when his dad died and when Helen left him. I mean down deep, Harold really is just a big kid and Helen and I were both kind of his mother. Now his dad was something again. I mean Harold always depended on his dad to get him out of jams, and to lay down the law for him. You can just imagine how he felt about them. Why . . . you can see over there on the end table. He's still got Helen's picture. See! (pointing)

**Jay Morris:** I see . . . he depended on them to take care of him.

**Mildred Sebring:** Well, yea -- that's kind of what I meant. Only now he has no one. Not only that, he's mismanaged the jewelry store for so long now that he may go bankrupt soon. It just seems like poor Harold has had everything go wrong at once. But as usual, he's brought it on himself.

**Jay Morris:** Mildred, how old is Harold now?

**Mildred Sebring:** Let's see . . . he'll be fifty-one years old this April.

**Jay Morris:** Um . . . and does he have any religious preferences?

**Mildred Sebring:** Well our family is Catholic, but we've never been regular church-goers. Now Harold never did like church. Even when he was a child. He said he felt caged in church and he didn't like all those rules. The result was that he fought us when we tried to get him to go. We finally gave up trying.

**Jay Morris:** Do you have any idea then what Harold believed?

**Mildred Sebring:** Humm . . . that's something I've never really thought about. (pause) I can tell you that he didn't like rules and discipline, that's for sure. I mean I think he really thought everyone was trying to tie him down or hold him back by orders, rules, or regulations. You've got to understand that Harold wasn't a thinker, and he never said anything like that. But his actions, like fighting going to church, and a few comments, make me think its true. But I want to say that Harold has slowed down some, and now he seems more depressed than anything else. But he still doesn't go to church.

**Jay Morris:** Are there any groups that Harold is still active in?

**Mildred Sebring:** No . . . none that I know of . . . he used to belong to one of the civic clubs . . . but I don't think he's gone for years.

**Jay Morris:** Well what specifically does he do with his time? Does he have any hobbies?

**Mildred Sebring:** Oh . . . he used to fish some, and he liked to sail. But he hasn't done that much in recent years. He reads a bit too. But he's been a pretty active fellow and reading was more of a pain than a pleasure. I don't know how much he reads these days. (Someone knocks on the door).

**Jay Morris:** (walks over to the door and opens it).

**Alice Bellows:** (enters in nightgown) Hi . . . I'm Alice from across the hall. (Mildred walks over and stands next to Jay). After all the commotion this evening, I just thought I'd drop over to see what happened. Anyway Mildred (they know each other) I couldn't sleep.

**Mildred Sebring:** Sure Alice come on in, this is Jay Morris from the Drug and Alcohol Center. I must warn you though, this place is a mess. (All walk to sofa and chair. Two sit and Mildred stands) Excuse me Alice . . . I think I'll make a pot of coffee. Would either of you like some?

**Jay Morris:** Um . . . sounds good . . . Make mine black.

**Alice Bellows:** No . . . not me . . . I really wouldn't be able to sleep the rest of the night. (Mildred walks away into the kitchenette).

**Jay Morris:** Well Alice what happened in here tonight?

**Alice Bellows:** Boy . . . you wouldn't believe it? Late this evening, as Joe and I were about to retire, we heard banging noises

and cussing coming from the hall. When he opened the door he saw Harold, drunk, out of his mind going into his apartment. Well, we thought that'd be the end of it, but we were wrong. About fifteen minutes later, we heard him sort of wail or cry . . . it was pathetic. I thought he said he killed him. Boy that really scared me. Then we heard all this swearing, and crying, and crashing; like he was tearing the place apart. It went on and on, and Joe finally went over and ask him to quiet down. But he wouldn't answer the door or stop. After what seemed like hours, we called the police. You know he kept everyone in this building awake, and he kept saying over and over that he'd killed someone. That really was scary. Jees . . . that was something! What's the matter with him anyway? Did he really kill someone?

**Jay Morris:** You got me. All I know is that he was terribly drunk when I arrived, and that he probably had been drunk for sometime. In fact, it was so bad that he's down at the hospital right now. Tell me Alice, did he mention where he had come from this evening? So far I know where he was late this afternoon, and know he came back from somewhere late this evening. What I can't figure out is where he was earlier in the evening.

**Alice Bellows:** No . . . he was much to drunk to talk too, so we didn't even try. But I think he mentioned the name "Hank" . . .

**Jay Morris:** In fact, I think that was who he kept saying he killed.

**Mildred Sebring:** (Looking very concerned): Hank huh? (pause) Hey Mildred! (shouts to kitchen) Did Harold ever hang around with someone named Hank?

**Jay Morris:** (Walking in with coffee tray): Who?

**Mildred Sebring:** Hank . . . a guy named Hank.

(thoughtfully): Hank . . . I've heard that name somewhere. It could be one of those drinking cronies of his. It'd almost have to be, because none of his old friends have a name like that. (phone rings, Jay answers it).

**Jay Morris:** Hello! (pause) Oh hi Don. (pause) He is huh. (pause) OK. (pause) Hey look, from what I've been able to find out, he could be suicidal. Will you alert the staff at the hospital? (pause) Another thing, ask Doc if he'll request a full battery of Psychologicals from the Center when he gets on his feet again. Say, a month or so . . . when he's seeing someone at the Center. Oh . . . one more thing. It seems that he was running around up here drunk, saying he killed someone tonight named "Hank." Will you check downtown and at the hospital to see if anything has been reported? (pause) Great . . . OK, see you. (hangs up and

goes back over to Mildred and Alice) Well, Harold is safe at the hospital now, but Don Mallory doesn't know a character named Hank either.

**Mildred Sebring:** Oh, this is so awful . . . (sipping her coffee) . . . I don't know what's got into Harold. I just don't know. Oh whatever is going to happen to him?

**Jay Morris:** Well, for starters he is going to have to be dried out at the hospital under medical supervision. Then, we're going to check out possible referrals to treatment agencies and perhaps Alcoholics Anonymous when he gets better. But we'll have to identify some of his specific problems first. For instance, it seems that although Harold has a history of excessive drinking and impulsiveness, some sort of incident occurred tonight which frightened him into wrecking this place as well as drinking himself into oblivian. (phone rings again, Jay answers). Hello. (pause) Oh hi Don. (pause) WHAT! (pause) Boy . . . How about that! (pause) Yeh. (pause).

**Mildred Sebring:** (thoughtfully:) NOT HANK . . . "TANK!" (very excited) It's "Tank" Kelly he was talking about Jay . . . the name is "Tank" . . . "Tank" . . . "Tank" Kelly.

**Jay Morris:** (He's excited now) Did you hear that Don . . . It's TANK . . . "Tank" Kelly that Harold was talking to. (pause) WHAT! You're kidding. (pause) Jesus . . . really! Well, you tell the nurses and all the staff to be ready to tell him the minute he can comprehend. It should change everything. Yes. I'll see you tomorrow. (hangs up)

**Mildred Sebring:** (tense and excited) What happened . . . What happened!

**Jay Morris:** Well, "Tank" Kelly was admitted to the hospital earlier this afternoon with a laceration to the head. It looks like Harold went drinking with "Tank" and they fought over a bottle. I guess Harold hit him over the head with it just as "Tank" passed out. Looks like Harold was so drunk that he thought he'd killed him. Anyway, that should be some good news to Harold when he gets back on his feet. But more important than that, the crisis is over and we can all go home. With a little luck and some careful planning Harold could be back on his feet raring to go in a week or two. But I would like to remind you, Harold has to begin to utilize some of the services of our local health care agencies in an ongoing way once he is dried out. I'll make the appropriate referral tomorrow so that someone is there to see him tomorrow. The rest will be up to him.

**Mildred Sebring:** OK . . . I'll help out all I can.

(Lights dim, curtain closes)

# APPENDIX B

## DRUG AND ALCOHOL CRISIS INVENTORY

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**NOTE:** This inventory is meant only as a guide for the kinds of questions to be asked in crisis. It is not to be filled out in a crisis situation by the crisis worker.

Name:_____ Date:_____

Education:_____ Age:_____ Occupation:_____

At present, do you live alone? _____yes _____no
If you do not live alone, list the names of the person(s) you live with. _____

_____

Do you live in a house, hotel, room, apartment, etc?_____

Marital status (circle one): never married, married, remarried, separated, divorced, widowed.

1. **Crisis Description**

a) In your own words, describe your present crisis. _____

_____

_____

b) How long has this been going on? _____

_____

c) How serious do you think this (these) problems are? _____

_____ no problem _____ moderate problem

_____ slight problem _____ severe problem

d) What have you already tried to overcome the crisis? _____

_____

_____

2. **Substance use**

The following code will be used to describe frequency of Drug and Alcohol use below:

0 — Never Tried
1 — Tried a couple of times
2 — Less than once a week
3 — Once a week
4 — Several times a week
5 — Daily
6 — Not a problem at time of admission

a)

| | CURRENT USE | | | | PAST USE | | |
|---|---|---|---|---|---|---|---|
| Drug | Use | Cost | Age Tried | Age Started | Age Started | Age Quit | Use |
| Marijuana | ___ | ___ | ___ | _____ | _____ | ___ | _____ |
| Hash | ___ | ___ | ___ | _____ | _____ | ___ | _____ |
| Hallucinogens | ___ | ___ | ___ | _____ | _____ | ___ | _____ |
| Barbiturates | ___ | ___ | ___ | _____ | _____ | ___ | _____ |
| Amphetamines | ___ | ___ | ___ | _____ | _____ | ___ | _____ |
| Tranquilizers | ___ | ___ | ___ | _____ | _____ | ___ | _____ |
| Heroin | ___ | ___ | ___ | _____ | _____ | ___ | _____ |
| Other Opiates | ___ | ___ | ___ | _____ | _____ | ___ | _____ |
| Methadone | ___ | ___ | ___ | _____ | _____ | ___ | _____ |
| Inhalants | ___ | ___ | ___ | _____ | _____ | ___ | _____ |
| Alcohol | ___ | ___ | 88 | _____ | _____ | ___ | _____ |
| Other | ___ | ___ | ___ | _____ | _____ | ___ | _____ |

b) Do you ever take drugs and alcohol together? _____ Yes _____ No

How often? _____

Primary_____ Secondary_____ Tertiary_____

Current symptoms of alcohol or drug problem: _____

_____

_____

3. **Drug History**

a) Have you ever been in a hospital or program for drug treatment? _____

| Hospital/ Program | Counselor/ Doctor | Type Of Treatment | Dates (To and From) |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

b) What is the longest period of time you have stopped using drugs? _____

A. On your own without the help of any program or hospital? _____

B. With help of a program? Date _____

C. How long did you remain drug-free after leaving program? _____

Length _____ Program _____

c) Do you frequently come into contact with people who use drugs?
_____ Yes _____ No

d) Describe any additional problems associated with drug use: _____

_____

_____

4. **Alcohol History**

a) What is your usual alcoholic drink?_____

b) When did you have your last drink?_____ Date_____

c) What is your most frequent drinking place.

Own place _____ Bar _____ No one place _____

Friends place _____ Street _____ Other _____

d) Do you usually drink

Alone _____ With some small group _____ No set style _____

e) Have you ever had

Blackouts _____ Convulsions _____ DT's _____ Associated with alcohol?

f) Describe any additional problems associated with alcohol use _____

_____

_____

g) Have you ever been in a hospital or program for alcohol treatment?

| Hospital/ Program | Counselor/ Doctor | Type Of Treatment | Dates (To and From) |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

h) How was your past treatment funded? _____

i) Are you presently a member of A.A. _____ Yes _____ No

j) What is the longest period of time you have stopped using alcohol? _____

A. On your own without the help of any program or hospital. Date _____
B. With the help of a program? Date_____
C. How long did you remain alcohol free after leaving a program?

Length:_____ Program:_____

k) Initial assessment of stage of alcohol use:

_____ Early (alcohol required for pleasure)

_____ Middle (Surreptitious drinking, defensive)

_____ Late (Life oriented around alcohol)

_____ Non-alcoholic

_____ Insufficient data to make immediate assessment

5. **Personal Information**

a) Date of Birth _____ Place _____

b) Circle any of the following that you experienced during your childhood?

| | | |
|---|---|---|
| nightmares | bedwetting | sleep walking |
| thumbsucking | nail biting | stuttering |
| fears | happy childhood | unhappy childhood |

c) What sicknesses did you have during childhood? _____

_____

_____

d) What sicknesses did you have during adolescence? _____

_____

_____

e) Any operations? _____

f) Any accidents? _____

g) Any present physical problem? _____

_____

h) List your four main fears:

1. _____
2. _____
3. _____
4. _____

i) Circle any of the following that apply to you:

| | | |
|---|---|---|
| headaches | dizziness | fainting spells |
| fast heartbeat | stomach trouble | worry |
| bowel problems | weakness | no appetite |
| anger | take pills to relax | drinking problems |
| nightmares | take pills to sleep | shakes |
| feel tension | conflict | takes drugs |
| feel depressed | suicidal ideas | allergies |
| unable to relax | sexual problems | shy |
| don't like weekends or vacations | work too hard | can't make decisions |
| can't make friends | feel like I'm no good | bad home conditions |
| can't keep job | memory problems | unable to have a good time |
| money problems | lonely | thinking difficulties |
| sweating | guilty | bored |
| life is empty | confused | little confidence |
| | not understood | |

wish you were dead | not very smart | feel unwanted
feel ugly | full of regret

Any other problems or difficulties? _____

_____

i) List any interests, hobbies or recreational activities you enjoy: _____

_____

k) How do you spend most of your free time? _____

_____

l) What is the last grade of school that you completed? _____

m) Do you have a high school diploma or equivalency? _____ Yes _____ No

n) List any college degrees earned: _____

o) How would you describe your school experiences:

_____ happy _____ unhappy _____ Uncertain

p) Do you make friends easily? _____

Do you keep them? _____

6. **Work History**

a) How many jobs have you had in the last five (5) years? _____

b) What is your usual occupation? _____

c) Are you now . . .

_____ employed fulltime _____ unemployed

_____ employed parttime _____ other _____

d) If employed, your present occupation is _____

e) If employed, What do you like about your present job? _____

f) If employed, what do you dislike about your present job? _____

_____

g) Have you had any special training? _____

_____

h) Do you have any goals or ambitions regarding work? _____

_____

7. **Financial Support**

During the last three (3) months, what have been your main source(s) of financial support? (Check as applies):

_____ none

_____ employment

_____ savings

_____ other, specify: _____

_____ welfare

_____ unemployment benefit

_____ family, friends

_____

8. **Military History**

a) Branch of Military _____

b) Rank of Discharge _____

c) Type of Discharge _____

9. **Arrest History**

a) Have you ever been arrested? _____ Yes _____ No

b) If yes, please give reasons and dates: _____

_____

c) Have you ever been confined in jail or prison? _____ Yes _____ No

d) If yes, please give reason and dates: _____

_____

10. **Religious History**

Do you consider yourself to be a religious person? _____ Yes _____ No

_____ uncertain

b) Were you brought up in any particular religion? _____

c) Are you presently involved in any religion? _____ Yes _____ No

d) How much does religion affect your present life?

_____ not at all _____ very little _____ somewhat _____ very much

11. **Sex Information**

a) Did your parents talk openly about sex at home: _____ Yes _____ No

_____ uncertain

b) When and how did you first learn about sex? _____

_____

c) How often do you experience anxieties or guilt feelings about sex?

_____ never _____ once in a while _____ often _____ very often

d) I would describe my present sex life as:

_____ satisfying _____ so so _____ unsatisfying

e) In what ways are you uptight about sex? _____

_____

_____

12. **Menstrual History**

a) Age at first period? _____

b) Were you informed or did it come as a shock? _____

c) Are you regular? _____

d) Do you have pain? _____

e) Date of last period? _____

f) Does your period affect your moods? _____

13. **Marital History**

a) How long have you known your present spouse or living partner? _____

b) How long have you been living together? _____

c) If married, how long have you been married? _____

d) How old is your spouse or living partner? _____

e) Does your spouse or living partner work outside the home?

_____ Yes _____ No Yes, describe type of work: _____

f) In your own words, describe what your spouse or living partner is like (per-

sonality, good points, bad points): _____

_____

_____

g) In what areas do you get along well? _____

_____

h) In what areas don't you get along well? _____

_____

i) Apart from your drinking, do you feel that your marriage is basically happy?

_____ yes _____ no _____ uncertain

j) Does your spouse/living partner have a drug or drinking problem.

_____ yes _____ no _____ uncertain

k) Does your spouse/living partner have any emotional or mental problem.

_____ yes _____ no _____ uncertain

l) If either g or h is yes, please describe: _____

_____

m) Please give the names and ages of your children and circle the names of the children who live with you: _____

_____

_____

n) Do any of your children have special problems? If yes, please describe: _____

_____

o) Have you been married before? _____ Yes _____ No

If yes, how many time and for how long? _____

_____

14. **Family Data:**

a) Father:

living or dead? _____

if dead, your age at time of his death? _____

cause of death? _____

if alive, father's present age? 95

work: _____

health: _____

b) Mother

living or dead?_____

if dead, your age at time of her death?_____

cause of death? _____

if alive, mother's present age? _____

work: _____

health:_____

c) Brothers and Sisters

number of brothers: _____ ages:_____

number of sisters: _____ ages:_____

When you were growing up, how did you get along with your brothers and sisters? _____

How do you get along with them now? _____

d) Describe what your father was like and how he felt towards you when you were a child:_____

_____

e) Describe what your mother is like and how she felt towards you when you were a child:_____

_____

f) In what ways were you punished as a child? _____

g) How did your parents get along with each other when you were growing up? _____

h) How would you describe your home life as you were growing up?

_____ happy _____ unhappy _____ uncertain

i) Were you able to talk easily with your parents when you were growing up?

_____ yes _____ no

j) Did your parents understand you? _____ yes _____ no _____ uncertain

k) Did you feel loved by your parents? _____ yes _____ no _____ uncertain

l) If you have a step-parent, give your age when parent remarried: _____

Describe your step-parent and how you feel about him or her: _____

_____

m) If you were not brought up by your parents, who did bring you up: _____

_____

n) How do you get along with your parents now? _____

o) Who are the most important people in your life? _____

15. **Previous Treatment**

a) Have you ever been hospitalized for psychiatric care? _____ yes _____ no

If yes, please state who, where, why: _____

_____

b) Have you ever been treated for drinking problems before?

_____ yes _____ no

If yes, please state when and where: _____ _____

_____

16. **Self-Description**

a) I am a person who _____

b) All my life _____

c) Ever since I was a child _____

d) One of the things I feel proud of is _____

e) It's hard for me to admit _____

f) One of the things I can't forgive is _____

g) One of the things I feel guilty about is _____

h) If I didn't have to worry about my image _____

i) One of the ways people hurt me is _____

j) Mother was always _____

k) What I needed from mother and didn't get was _____

l) Father was always _____

m) What I wanted from my father and didn't get was _____

n) If I weren't afraid to be myself, I might _____

o) One of the things I'm angry about is _____

p) What I need and have never received from a woman (man) is _____

_____

q) The bad thing about growing up is _____

r) One of the ways I could help myself but don't is _____

_____

# APPENDIX C

# TYPES OF OTHER DRUG INTERACTIONS WITH ALCOHOL

## TYPES OF OTHER DRUG REACTIONS WITH ALCOHOL

| Kind Of Reaction | Definition | Drug | Symptoms |
|---|---|---|---|
| A. Independent or Negative | Each does its own job; 1+1=1−1 | Oral Contraceptives: (Normyl, Ortho-novum, Ovral) | "Pill" seems to increase rate of alcohol absorption resulting in increased BAL. |
| | | Illicit: Lysergic Acid Diethylamide— "LSD"; "Acid" | Reported but questionable precipitation of LSD flashbacks; alcoholics may be resistant to 200-400mg. LSD "o." |
| | | Mescaline — "Mesc" | No report drug interaction. |
| | | Psylocybin — "Mushrooms" | No report drug interaction. |
| | | Cocaine — "Coke" | No interactions have been reported? See Central Nervous System' stimulants. |
| | | Nicotine: (Cigarettes) | Clinically important drug interaction not established? See tobacco. |
| | | Anti-Infective: Penicillin | No reaction, but alcohol speeds excretion and penicillin is less effective. |
| | | Nutrient: Vitamins | No reaction (except decreased absorption adds to malnutrition in alcoholism). |
| B. Summative or Additive | Combined effect of simple addition 1+1=2 | Major Tranquilizers: 1. Phenothiazines — chlorpromazine (Thorazine) thioridazine (Mellaril) prochlorperazine (Compazine) trifluoperazine (Stelazine) perphenazine (Trilafon) | Additive CNS depression (sedation prominent). Impairment of muscle coordination and judgment; caution should be used when driving or operating machinery. |

TYPES OF OTHER DRUG REACTIONS WITH ALCOHOL

| Kind Of Reaction | Definition | Drug | Symptoms |
|---|---|---|---|
| | | 2. Haloperidols (Haldol) | |
| | | Illicit:<br>Marijuana (Pot, hash, grass, THC) | "Feel better" "bigger" effect than alcohol alone: Motor incoordination greater. X-tolerance. |
| | | Anesthetic:<br>(tetrachlorethylene) | Respiratory and cardiac failure. |
| | | Antihypertensives:<br>alpha-methyldopa (Aldomet) | May increase sedation with initial treatment. Increase renal and peripheral vasodilatation. |
| | | guanethidine (Esimil: Ismelin) | Enhanced postural hypotensive effect may produce dizziness or fainting spells. |
| | | rauwalfia Alkaloids<br>deserpidine (Enduronyl; Harmonyl)<br>reserpine (Butiserpazide; Hydromox; Serpasil) | May increase sedation with initial treatment. |
| C. Synergistic or Potentiation | Multiplication Effect<br>1+1=3, 4, or 5 (more than 2) | Sedative-Hypnotics:<br>Barbiturates — "Downers"<br>amobarbital (Amytol)<br>butabarbital (Butisol)<br>pentobarbital (Nembutal) "Yellows" | Potentially lethal in large doses; "Hollywood" death.<br>Enhanced CNS and respiratory depression. Cross-Tolerance. Nausea |

TYPES OF OTHER DRUG REACTIONS WITH ALCOHOL

| Kind Of Reaction | Definition | Drug | Symptoms |
|---|---|---|---|
| | | phenobarbital (Luminal and various others)<br>secobarbital (Seconal) "Reds"<br>tuinal "Rainbows" | with chronic heavy consumption of alcohol. |
| | | Non-barbituates<br>chloralhydrate (Felsules; Noctec) "Mickey Finn"<br>chloralbetaine (Beta-Chlor)<br>ethochlorynol (Placidyl)<br>glutethimide (Doriden)<br>methaqualone (Quaalude; Sopor — "Rorer"; Optimil; Parest; Somnafac; Mandrax) | Vomiting<br><br>If shooting — euphoria; can't talk; nod. (Used to decrease pain of heroin withdrawal). Tolerance leads to overdose. Withdrawal leads to severe convulsions. |
| | | carbromal (Carbrital)<br>flurazepam (Dalmane)<br>paraldehyde; ethinamide (Valmid)<br>methyprylon (Noludar)<br>bromides, phencyclidine hydrochloride (PCP, Crystal joint, CJ. Tic Tac). | Flashbacks days later; death. |
| | | Minor Tranquilizers: (Also used as Muscle Relaxants): | |

TYPES OF OTHER DRUG REACTIONS WITH ALCOHOL

| Kind Of Reaction | Definition | Drug | Symptoms |
|---|---|---|---|
| | | chlordiazepoxide (Librium; Libritabs) | At social drinking levels, there is usually minimal synergixm of CNS depression. |
| | | chlorazepate (Trankene)<br>diazepam (Valium)<br>flurazepam (Dalmane)<br>lorazepam (Serax)<br>prazepam (Verstran) | At more than social drinking levels increased sedation and CNS depressant effects. |
| | | hydroxyzine (Atarax; Vistaril)<br>meprobamate (Equanil; Miltown)<br>tybamate (Solacin; Tybatran) | In heavy chronic drinkers Cross-tolerance and accidental poisoning. Driving or operating machinery is difficult. Increase of CNS depressant effect. |
| | | Analgesics:<br>1. Narcotics — real and synthetic opiate derivatives;<br>Morphine "Dreamer", "M", heroin, "junk", "H"<br>Methadone (dolophine) — "Dollies"<br>Codeine (cough syrups with codeine; Novahistine Expectorant (Elixir of Terpin Hydrate with Codeine; Phenaphen with codeine)<br>meperidine (Demerol), dilaudid, talwin | X-tolerance<br>Chronic heavy drinkers may have tolerance to depressant effects, but usually there is.<br>Increased CNS and Respiratory Depression. |

TYPES OF OTHER DRUG REACTIONS WITH ALCOHOL

| Kind Of Reaction | Definition | Drug | Symptoms |
|---|---|---|---|
| | | 2. Non-narcotics;<br>Salicylates<br>acetylsalicylic acid (Aspirin; Excedrin) | Increased G.I. blood loss and damaged-stomach lining induced by aspirin, Excessive alcohol intake and aspirin may lead to severe G.I. bleeding. |
| | | acetaminopehen (in extra-strength Tylenol<br>phenylbutazone (Butazolidin)<br>d-propoxyphene (Darvon) | Permanent liver damage or death if 14 tabs. Plus regular drinking.<br>Driving and psycho-motor skills decreases. |
| | | 3. Anesthetics (ether, chloroform) | Increased CNS and respiratory depression. |
| | | Antidepressants:<br>1. Tricyclic<br>amitriptyline (Elavil)<br>doxepin (Sinequan)<br>imipramine (Presamine; Tofranil)<br>nortriptyline (Aventyl)<br>protriptyline (Vivactil) | Increase CNS depressant effects. Improved motor skills following initiation tricyclic therapy (takes 3 weeks to notice mood change.) |
| | | 2. Monoamine Oxido<br>isocarboxazid (Marplan)<br>pargyling (Eutonyl)<br>tranylcypromine (Parnate) | Mechanism unknown. MAO inhibits metabolism of tyramine in chianti wine; Increased sedative effects, Nausea, vomiting, and headache. Increased blood pressure, heart palpita- |

TYPES OF OTHER DRUG REACTIONS WITH ALCOHOL

| Kind Of Reaction | Definition | Drug | Symptoms |
|---|---|---|---|
| | | | tions, Hypertensive crisis (with chianti wine and beer). |
| | | Antihistamines:<br>1. Ethanolamines (Prominent Sedation)<br>diphenhydramine (Benadryl)<br>diphenylpyraline (Diafen; Hispril spansule) | CNS depression. Sedative effects (vary with class of antihistamine). |
| | | 2. Ethylenediamines (Moderate Sedation)<br>methapryiliene (Histadyl; Nytol)<br>tripelennamine (Pyribenzamine) | Drowsiness intensified making driving and operation of dangerous machinery a hazard. |
| | | 3. Alkylamines (Minimal Sedation)<br>brompheneramine maleate (Dimetane)<br>chlorpheneramine maleate (Chlor-Trameton; coricidin) | |
| | | 4. Phenothiazines (Moderate sedation)<br>promethazine (Phenergan; Synaglos) | |
| D. Antagonistic | Effect may slightly oppose CNS Depression of alcohol | Central Nervous System Stimulates:<br>1. Power -Picrotoxin Strychnine | May keep alcoholic in coma alive, but might induce convulsion. |

## TYPES OF OTHER DRUG REACTIONS WITH ALCOHOL

| Kind Of Reaction | Definition | Drug | Symptoms |
|---|---|---|---|
| | | 2. Milder — Cocaine — "Coke" | May look alert, but coordination poor. |
| | | Tricyclic Antideprssant: desipramine (Norpramine) | May cause hyperexcitability. |
| | | amphetamines (Benzedrine) — "Bennies" (Biphetamines) — "Black Beauties"; "Speed" | Antagonizes CNS depression of alcohol, but unpredictable. Psychosis such as paranoid Schizophrenea may occur. Aggravate withdrawal from alcohol. |
| | | dextroamphetamines (Dexedrine) — methylpheniadate (Ritalin) | No motor coordination improvement, but feel and look more alert. |
| | | 3. Very Mild — caffeine (in aspirin, Phenacetin Caffeine Capsules, Empirin, No Doz); (Soft drinks with Caffeine coffee, tea, cocoa) | May cause hyperexcitability. |
| | | pentylenetetrazol (Metrazol) | May induce convulsion. |
| | | tobacco-nicotine — (especially high sugar content tobacco) | |
| | | Anti-Tuberculosis Agent: isoniazid (Nydrazid) | Decreased bacteriocidal effect in chronic alcohol use. |

TYPES OF OTHER DRUG REACTIONS WITH ALCOHOL

| Kind Of Reaction | Definition | Drug | Symptoms |
|---|---|---|---|
| E. Amythystic | Reverses Alcohol Intoxication | L-Dopa; Dopram; aminophylline; (propranolol?) | Intoxication relieved? Sometimes propranolol has additive effect. |
| F. Disulfiram (Antabuse) like | Toxic-Reaction | Diuretic:<br>ethacrinic acid (Elicrine) | Headache, perspiration. |
| | | Oral Anti-Diabetics:<br>chlorpropamide (Diabinese)<br>tolbutamide (orinase) | Short of breath, face flushed, tachycardia, vasodilation, convulsion. |
| | | Anti-Infectives:<br>chloramphenicol (Chloromycetin)<br>furazolidone (Furoxone)<br>griseofuloin (Fulvacin U/F)<br>metronidazole (Flagyl) | Abdominal cramps, vomit, flush. |
| | | Anti-Malarials:<br>quinacrine (Atabrine, Mepacrine) | |
| | | Vasodilator:<br>tolazoline (Priscoline) | |
| G. Other | | Tabacco:<br>Alcohol dissolves tars in tobacco smoke causing Pyridine plus alcohol | Increase alcohol intoxication.<br>cancer of head, neck, esophagus, degenerates optic nerve. |

TYPES OF OTHER DRUG REACTIONS WITH ALCOHOL

| Kind Of Reaction | Definition | Drug | Symptoms |
|---|---|---|---|
| | | Metals and Solvents:<br>Alcohol dissolves toxic metals & organic solvents (CC1-4) causing | poisoning, confusion. |
| | | Anti-Convulsants:<br>clonazepam (Clonopin)<br>diphenylhydantoin (Dilan, Dilantin) | Chronic or heavy alcohol use makes epileptic tolerant to anticonvulsants. |
| | | Anti-Anginal Preparations:<br>1. Nitrates<br>nitroglycerin (Nitrong; Nitrostat)<br>pentaerythritol tetramotrate (Antora; Pentritol; Peritrate) | Hypotension, resulting from enhanced dilatation of blood vessels. Further decreased blood pressure. |
| | | 2. Peripheral vasodilator tolzaine (Priscoline) | Possible disulfiram-like reaction. |
| | | Anti-Coagulants:<br>bishydroxycoumarin (Dicumarol)<br>warfarin sodium (Coumadin; Panwarfin) | Unpredictable:<br>1. occasional increased sensitivity to drug with acute intoxication.<br>2. with chronic heavy alcohol use decreased blood clotting intensified. |

TYPES OF OTHER DRUG REACTIONS WITH ALCOHOL

| Kind Of Reaction | Definition | Drug | Symptoms |
|---|---|---|---|
| | | | 3. with moderate alcohol use, no reaction if liver is normal. |
| | | heparin (Lipo-Hepin; Panhepin) | must take same amount daily or it potentiates. |
| | | Diuretics: ethacrinic acid (Edicrine) | dehydration |
| | | Anti-Diabetic Agents: Insulin (Illetin) | May augment hypoglycemic effect of alcohol, control of diabetes more difficult. Possible severe hypoglmcene. |
| | | chlorpropamide (Diabinese) | Possible disulfiram-like reaction. |
| | | tolbutamide (Orinase) | Possible disulfiram-like reaction. Increased hypoglycemic effect, particularly in fasting patients. Decreased hypoglycemic effect with chronic alcohol use. |
| | | Hydrocarbon Vapors: paint, glue, petroleum, aerosols | X-tolerance with alcohol. Sensitizes heart to adrenalin and may cause tachy cardia and heart block. |

# APPENDIX D

# LISTING OF HALLUCINATIONS

---

I. Alcohol Related Hallucinations

A. **Stimulus Source:** No external stimulus, but the percept is distorted by inner need only when intoxicated.

B. **Content:** bizarre and unreal; may include accusatory or threatening auditory hallucinations.

C. **Behavior:** drinking initiates bizarre psychotic-like behavior. However, when sober this person may appear aloof, withdrawn, avoidant, denying, but distinctly more appropriate.

D. **Historical Material:**

1. One or both parents frequently alcoholics
2. Client frequently has early history of bedwetting.
3. Often has poor work history.
4. Often has arrest record.
5. Has frequent marital and family problems.
6. Often times has been admitted to inpatient or outpatient Alcoholism or mental health facilities.

II. Alcohol Induced Delerium Tremens

A. **Stimulus Source:** Percept is triggered by minor external stimulus, but is distorted by withdrawal from infested alcohol.

B. **Content:** Hallucinations consist of small fast animals (plus an occasional spider). May be more intense in the dark.

C. **Behavior:** Prior to onset may be avoidant, denies, sensitive to criticism, less suspicious than doper, more appropriate than a

psychotic, and may be impulsive. At or after onset, may experience course tremors, heightened sensitivity to light, noises, restlessness and insomnia.

D. **Historical Materials:** (See Section D of Number I above)

III. Korsakoff's Syndrome

A. **Stimulus Source:** No internal or external stimulus. The illusion of percept distortion is created by memory loss due to mild brain damage.

B. **Content:** No content . . . is not really a hallucination.

C. **Behavior:** appears overly talkative, confused at times, disoriented, confabulates, and has memory lapses.

D. **Historical Material:** (See Section D of Number I above)

NOTE: This syndrome only occurs with long term Alcoholism.

IV. Drug Related Hallucinations

A. **Stimulus Source:** No external stimulus; percept is distorted by inner need only when drugs other than alcohol are taken.

B. **Content:** Content is bizarre and unreal in much the same way as Alcohol related hallucinations, since both derive their content from inner need states.

C. **Behavior:** Other drug ingestion initiates bizarre psychotic-like behavior. Prior to drug ingestion, the person-in-crisis is likely to seem alienated and withdrawn, abstract in thought, and somewhat unconventional.

D. **Historical Material:**

1. One or both parents are frequently Alcoholics and/or other kinds of drug abusers.
2. May have an early history of bedwetting.
3. Often has a poor work history.
4. Often has a history of arrests.
5. Frequently has marital or family problems.
6. Often has frequent admissions to outpatient centers and inpatient facilities for psychiatric problems.

V. Drug Induced Hallucinations

A. **Stimulus Source:** Minimal external stimulus is needed usually for such hallucinations.

B. **Content:** Imaginative, but more structured (less bizarre) than hallucinations derived entirely from internal need states. In addition, uppers may precipitate paranoid ideation.

C. **Behavior:** While hallucinating, the person-in-crisis may appear uninvolved, preoccupied, and self-contained. He may sometimes also act-out.

D. **Historical Material:**

1. One or both parents are frequently alcoholics and/or some other kind of drug abuser.
2. May have an early history of bedwetting.
3. Often has a poor work history.

4. Often has a history of arrests.
5. Frequently has marital or family problems.
6. May have frequent admissions to outpatient centers for behavioral problems.

VI. Hallucinations Caused By Underlying Psychiatric Problems

A. **Stimulus Source:** Percept distortion is created primarily from the press of inner need states. This dis ortion can occur anytime, and is **not** related in any way to Drug or Alcohol ingestion.

B. **Content:** Bizarre and unreal. Unrelated to the ingestion of chemicals. Unrelated, for the most part, to the crisis environment of the person-in-crisis.

C. **Behavior:** Withdrawn, shy, sometimes bizarre and very inappropriate behavior.

D. **Historical Material:** Frequently no family and little or no work history is evident. Sometimes a history of inpatient psychiatric treatment is present.

VII. Diabetic's Insulin Shock

A. **Stimulus Source:** Confusion and disorientation occur when diabetics discontinue use of insulin. At times it seems that hallucinations are present, but closer examination oftentimes reveal perceptual clarity.

B. **Content:** No content . . . not really a hallucination.

C. **Behavior:** Functions normally until insulin treatment is stopped and shock sets in.

D. **Historical Material:** Medical history of diabetes requiring insulin treatment.

VIII. Arterioscherosis (Hardening of the Arteries)

A. **Stimulus Source:** Confusion, disorientation, and hallucinations occur in older persons in crisis who suffer from hardening of the arteries. Percept distortion in this case has only a physical inner stimulus which diminishes when that person is at rest and can get more oxygen to his brain. Onset may occur late in the waking day, and may diminish or dissappear after rest.

B. **Content:** It has the same bizarre and unreal quality that hallucinations caused by underlying psychiatric problems have. However, they vary according to the time of day and the amount of rest that the person-in-crisis gets.

C. **Behavior:** This person should seem well-oriented and appropriate until the onset of hallucinations. At onset, psychotic-like behavior should occur.

D. **Historical Material:** Usually is a person over forty five years of age.

IX. Mental Retardation or Brain Damage

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A. **Stimulus Source:** It is not at all clear whether there is an external stimulus source in these cases. However, in my opinion, they are primarily generated from internal need states and are not at all

dependent on external stimuli.

B. **Content:** Rather simple, stereotyped, and unimaginative hallucinations are evidenced.

C. **Behavior:** May appear rather unsophisticated and dull. In the case of brain damage, coordination sometimes is effected.

D. **Historical Material:**

1. Possible high school drop out, or poor grades.
2. In the case of mental retardation, it may run in the family.
3. In the case of brain damage, difficult births and/or accidents responsible for the injury are sometimes identifiable.

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# ABOUT THE AUTHOR

Floyd Sours has worked in the field of Alcoholism and/or Drug Abuse for fifteen years as a clinical psychologist. In 1966, after completing his coursework for his master of arts degree from Bradley University in Peoria, Illinois, he began work at Alton State Hospital in Alton, Illinois, doing psychotherapy and testing under the supervision of several licensed clinicians in a structured in-hospital internship program. In 1969, he became the Director of the inpatient alcoholism program within the hospital. In 1970, Mr. Sours moved to Maysviile, Kentucky, where he was the Alcoholism and Drug Abuse Director for the local comprehensive Mental Health Center. His move to Ohio occurred in 1972 when he was offered the job as Professional Director of the Council on Alcoholism and Drug Abuse in Ashtabula, Ohio. Later, in 1974, he became the Regional Administrator of the Eastern Ohio Regional Alcoholism Council, a job which requires the management of federal and state alcoholism money to a nine county area, as well as planning and coordinating responsibilities. Today he, his wife and two children live in the Cambridge, Ohio area, where he works as a Regional Alcoholism Administrator and

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